DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 23

32 Registrar's Signature

			For State Registrer	State of Ma	aryland / Depa	rtment of He			ene g. No 2005	27502
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Death	1	3. Time of Death
	Physicia /Medic			echt				August	20 2005	12:57 a ^M
	Examin	er	4a. Facility Name (If not institution, give Genesis Cromwe			4b. City, Town, or L Towson	ocation of Death		4c. County of Deal	
	Franci		5. Social Security Number 6. S		(In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
	Funeral Director			□M 2 X F	70 Yrs.	Months Days	Hours Min.	(Month, Day, June 19	, 1935	Peru
ī	pur &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla f shor	-O	Md. Baltimor	٠-	Baltimo					1 ☐ Yes 2 ☑ No
	r 28e-	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	puntry?
	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "netural", or Items 23e or 28e-f show event. I've Madral Exam har mutter notified at	Funeral Director	6700 Canongate Rd			21	.239		USA	
	er dea	nue	11. Marital Status	12. Was Decedent E Armed Forces?		Vas Decedent of His I Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2	urs afti	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	Yes 2 No	Specify:		Specify: Per	uvian
5	72 hou		15. Decedent's Ec		16a. Deced	lent's Usual Occupat kind of work done du	ion	1	16b. Kind of Business/	Industry
Ž	vithin 7.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life. L	memaker	ming most of working	<i>,</i> 9	Own Ho	mo
V	filed w Hygie ther t	e Co	12 17. Father's Name (First, Middle, Last)		110		18. Mother's Name	(First, Middle, M		ille
0	ld be i ental ked o ic eve	To Be		quez			Antonia	•		
a y	shou and M s mar	-	19a. Informant's Name/Relationship (ype, Print)	19b. Mailin	g Address (Street ar	nd Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)
ž.	and 2 ealth m 27 I		Mr. Oliver R. Bred	ht/ Husbar		Canongate				
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural; or Items 23e or 28e-1 show any rightry or other treumetic event, It's Microsal Examiner in antice notified at angle.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo				20c. Location - City or	
Dallillor	artmer ortent injury		* 4 □ Donation * 5 □ Other (Specify 21. Signature of Funeral Service Licer		Hilltop S	Name and Address	of Facility	2005	Towson, M	d.
Ö	Depa Impo any ir		1 Muchaet	of Two	VI	Ruck Tows 1050 York	onFunera			
1	4,		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	ations that caus	The death. Do not ente	er the mode of dying,	, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Cara	har 1	Arrythin	ma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	0				
	9	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury	b. Due to (or as a	a consequence of):					
	cuted nd ransit	Examiner	that initiated events	c						
, o o	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):					
000	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai		d						
5	n certil	□/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Tr			23d. Date of del	ivery
0	res that the death certifica igned by the attending pt be detached for use as t	Physician/Med	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
ر ا	hat thi id by t detach		9 Unknown Part II. Other significant conditions of	ontributing to death be	ut not resulting in these	Marwing cause giver	n in Part I	23e Did tob	acco use contribute to	the cause of death?
colus,	uires t signe Id be (d by	End Stag	e of	Renal	D13-en	80	1 🗆 Ye		. /
2	s been si s should	oiete	Diabetes	mell	itus			24a. Was ar	24b. Were au	itopsy findings available
ב	sicien: The law s certificate has b lirector, page 2 s	Completed	Hypertens	n				autopsy perform		completion of cause of 2□ No
<u> </u>	cien: ertifica	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one	9)	
5	ding Physi n. After this c funeral dire	٦.	1 Yes 2 No	Hospital: 1 ☐ Inpatie			4 Wursing Mor		nce 6 Other (Spe winjury occurred	cify)
5	ding th. : After s funer	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year) Injury	Work?	es 2 □No	.bc. Describe no	w injury occurred	
<u> </u>	Atter	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, str	eet, factory, office	2	28f. Location (Str City or Town,	reet and Number or Ru State)	ıral Route Number,
5	itel or irs aft rel Dir iled in									
	o the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification placed in the funeral director.	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or invited	n occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier)		29c. License	number	29	d. Date signed (Mont	h, Day, Year)
			> Chillie Gr	W, MD		Deas	9855		August.	22 2005
	2 1		30. Name and a cress of person who	completed cause of de	eath (Item 23a) (Type,	Print) Qin	gin for	0		
1)		31. Date filed (Month, Day, Year)	aven 1	ar's Signature	Daldim	vore,	MP	21239	
	Sta Registr		AUG 2.		SUBJ A	Down Baltim Apoli			•	

		1	For State Registrar	State o	of Maryland		artment o				jiene _{eg. N} 201	05	27503
			Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia		Janice	Critzman						August	18	2005	4:15 P ^M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, To	wn, or Loca	tion of Death		4c. Count	y of Death	
			2908 Gladnor R	oad				Pasade				ne Aru	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7, Age (In yrs. la		If Under 1 Months [Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp	lace (State or Foreign try)
п	Director		213-26-4332	1 W 2 ZZ	74	Yrs.				Sept. 2	<u> 1930</u>		MD
	pu 🗼	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	sho	5			D.								1 ☐ Yes 2 🛣 No
	he N	Funeral Directo	Maryland Anne	<u>Arundel</u>	P (asader	10f. Zip C	ode			10g. Citizen of	What Coun	itry?
	with t	급		Rd.				2112	22			USA	•
	eath	era	2908 Gladnor	12 Was Dec	cedent Ever in U.S	. 13.	Was Deceder			pecify Yes or No- o Rican, etc.)	14. Ra	ce - Americ	an Indian,
	lter d	두	1 □ Never Married 2 □ Mar	ried 1 ☐ Yes	orces? 2 🕱 No					o Rican, etc.)		ick, White,	
336	urs at	β	3 Widowed 4 □ Divorced	If Yes G	ive		1 □ Yes 20)	Ų No Sp∈	ecity:		Speci	か: Whi	те
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exandrat must be motified at	Completed by	15. Deceder	nt's Education ast grade completed	,	16a. Dece	dent's Usual (Occupation	most of wor	kina	16b. Kind of E	Business/Ind	dustry
215	within 7 ene. than "r	e de	Elementary/Secondary (0-12)	-	(1-4or 5+)	life.	DO NOT use	retired)					
2121	ed wil	ပ္ပ	9				<u>lomemal</u>		14-16-24-14-	- (Final Addd)		<u>useho</u>	1d
Maryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural," raumatic event, the Medical Exa	Be	17. Father's Name (First, Middle,	Last)				18. 1		ne (First, Middle,			
yla	ould b Ment arke	ဥ		Hooper				2	Minr		Presser		Codel
Nar	2 sh and Is m		19a. Informant's Name/Relations				•			ral Route Numbe			C008)
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples in use the modified at		William Critzm	<u>an, Jr</u>			Gladr sition (Name		1., Pas	sadena, I	9D 2112 20c. Location		wn State
ore	ges 1 t of H If ite or ot		20a. Method of Disposition 1 Danial 2 ☐ Cremation	3 Removal from	State Cei	metery, cre	natory or other	er place)				•	
Ē	Pa tmen tant: jury		`4 □Donation 5 □Other (5		Lou				y¦ Aug		<u>Baltir</u>		
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service	UCENSEE	7		2. Name and						me, P.A.
	403 8 Q		23a. Part1. Enter the disease, o	Hall	sourced the death	Do not en	3111 MC	ountai	ch as cardiac	, Pasadn	ea, MD	21122	Approximate
			shock, or heart failure. List	t only one cause on	each line.							ļ	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Coma e	s trive	e H	ear t	tail	ive_			
	/Medical Examiner		Toodking III do Luiy						2.1	7	230000		
		_	Sequentially list conditions,	b. Due to	o (or as a conseque	ence of):	mct)	ve y	ulmor	lary o	Pisease	2	
	pet	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< A	rterio c		2 2 2 2	cal lor	dis	ease_			
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	C. Due to	o (or as a conseque	ence of):	o vas	00 (4.					
160	ate be ex nysician he burial	cal E			Corono	nı i	Artou	Di	seas	e			
687	ficate physis the			0.		J					1		
Box (The law requires that the death certificate be execute has been signed by the attending physician and page 2 should be detached for use as the buriat-tra	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregnan	icy	7=:				23d. D	ate of delive	•
ă	death a atte	icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pre	birth 2 ☐ Fetal gnant at time of de		∃Ectopic pre(∃ Other <i>(spe</i> c				M	onth	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unk	nown								
	es that igned b	by P	Part II. Other significant conditi	ions contributing to	death but not resul	lting in the u	nderlying cau	se given in	Part I.	23e. Did to	bacco use cor		ne cause of death?
rds	w require been sig should b	be	COPD P	eriphra	1 vasco	lav	diseas	<u>e</u>		101	′es 2□No	3 Prob	eably 4 □Unknown
00	s bee	olet	Hypertensi	on Hy	sperlipi	dem	a	anth	いから	24a. Was		. Were auto	psy lindings available impletion of cause of
Re	The lav	Completed	Osteenor	2 (1)),					perfo 1 ☐ Yes	med?	death?	2.2 No
tal		0	25. Was case referred to medica					26.	Place of Dea	ath (Check only o	**		
Division of Vital Records,		To B	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2 E	ER/Outpatie	nt 3 DOA	Other: 4	I ☐ Nursing H	lome 5 Resid	lence 6 🗆 Ot	her (Specif	y)
ō	ding Phys n. After this funeral di	L.	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o	of 280	c. Injury at Work?		28d. Describe h	now injury occu	irred	
<u>0</u>	Attendin death. ctor: Afi y the fur	atlo	2 LI ACCIDENT	tigation			М	1 🗆 Yes	2 No				
Vis	r Atte	t t	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minad 289. Plat	ce of Injury - At hor ding, etc. (Specify)	me, farm, st	reet, factory,	office		28f. Location (S City or Tox		iber or Rura	al Route Number,
	rs afte rs afte al Dir	Certification:											
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medica	ing Physician: To t I Examiner: On the	basis of examinati	vledge, dea ion and/or in	th occurred at westigation, i	t the time, do n my opinio	ate and place n, death occu	a, and due to the urred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
	the hin 2- the f	Medi	one)	and ma	inner stated.			License nur			29d. Date sign		
\	vitl To	1	29b. Signature and title of certifi	Cher & Le	- 440			D292			8 - 10		
,	1							2010	~ 1		,		
6	11		30. Name and address of person			asad		10 :	21122	CANDA	THE CL	ANDI	ER MD
>			31. Date filed (Month, Day, Year		Registrar's Signat		viu .						
	Regist	ate rar	dt .		E	H 1	nest s						
			11451	UVVV	DIFFERSAL A S	F- 54							

			١.	For State Registrar	State of Marylar		nt of Health and I te of Death		ne No. 2005	27504
				1. Decedent's Name (First, Middle, L	ast)			2. Date of Death Month	Day Year	3. Time of Death
_		Physici		Robert Mark Clem	ent			August 1	8, 2005	8:33 P. M
€	}	/Medic Examir		4a. Facility Name (If not institution, g	ive street and number)	4b. City	, Town, or Location of Deat	h	4c. County of Deat	h
				Stella Maris Hos	pice	9	imonium			ce County
		Funeral		Social Security Number 6.	Sex 7. Age (In yrs. 1 X M 2 ☐ F	Months	or 1 Year If Under 24 Hrs. Days Hours Min.	(Month, Day, Ye	9. Birti	hplace (State or Foreign untry)
	0	Director		064-50-3277	47	Yrs.		Sept.14,1	.957 Wich	nita Falls,
		pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
		sho	5							1 ☐ Yes Z∰No
		28a-f	ecto	Maryland Freder 10e. Street and Number	rick County No	ew Market	ip Code	100	. Citizen of What Co	untry?
		with t	ā		a	102	21774		nited Sta	•
		within 72 hours after death with the Maryland ene. 'than "natural', or Items 23e or 28e-f show the Medical Examinat Ite notified at	Funeral Director	6520 Ringrock Roa	12. Was Decedent Ever in L	J.S. 13. Was Dec			14. Race - Ame	
		ter d	S	1 □ Never Married 2 🖾 Married	Armed Forces?		edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
p.m	36	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2⊠ No Specify:		Specify: V	Mhite
	5-0036	2 hou	ted	15. Decedent's	Education	16a. Decedent's Us	ual Occupation work done during most of wo	161	b. Kind of Business/	Industry
33	215	n" ni	ple	(Specify only highest s Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		Antique F	urniture
ö	212	d with	Completed	12	04	Entre	reneur		Stor	
10		e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, La	st)		18. Mother's Na	me (First, Middle, Mai	den Sumame)	
2005	lar	Aental Aental rked o	ToE	Gene G. Clement				Boydstun		
7	aryland	2 should be filed withlr and Mental Hygiene. is marked other than eumatic event, the Mi		19a. Informant's Name/Relationship	(Type, Print)		ss (Street and Number or R			Zip Code)
18,	Σ	1 and 2 Health a om 27 is		Mrs.Elizabeth A.			ock Road Ne			21774
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other treumatic event, the Medical Examinating must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3	20b.	Place of Disposition (N cemetery, crematory of	ame of other place)	Date 200	c. Location - City or	Town, State
AUGUST	Ē	Page nent on int: If		`4 □Donation 5 □ Other (Spe	city)	ans Funeral	Chapel Aug.	20,2005 F	orest Hil	1, Maryland
361	alti	permit. Pag Depertment Importent: I any injury c		21. Signature of Funeral Service Lic	censep A	22. Name Peace	and Address of Facility uI Alternati	ves Funera	1&Cremati	on Ctr.P.A.
A	m	Depermine Depermine Permine Pe		Jeffrey	7. Jan	2325	York Road Ti	monium, Ma	ryland 2	21093
		Physician /Medical Examiner	er	23a. PArt. Briter the disease, or constitution of the state of the sta	a. METASTATIC Due to (or as a conse	guence of):		correspiratory arrest		Approximate Interval Between Onset and Death
	3760,	uires that the death certificate be executed signed by the attending physician and d be detached for use as the buriat-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	quence of):				
	89	ng pl	Med	IF FEMALE:						
	.O. Box	ne death certifica the attending ph thed for use as th	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 Ectopic			23d. Date of del Month	livery Day Year
	S, P	requires that the een signed by th hould be detache	by Ph	Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	cause given in Part I.		_	o the cause of death?
	Record	w requir been si should	ted					10 163	20,10	X
CLEMENT	ecc	S C S	ple					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Ξį	H	The la	NO.					performe 1 ☐ Yes 2 X	d? death? I No 1 ☐ Yes	2 No
IJ	ita	yeicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				ath (Check only one)		
XT.	>	0 0 A	10	1 Yes 2 No		☐ ER/Outpatient 3☐				ecify) HOSPICE
ROBERT	0	ding Ph. h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
RO	Division of Vital	ter deal	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be Geo Place of Injury At	home, farm, street, fact	1 ☐ Yes 2 ☐ Noory, office	28f. Location (Stre City or Town.	et and Number or Ri State)	ural Route Number,
		To the Hospitel of within 24 hours of To the Funerel D completely filled in	edical	one)	Physicien: To the best of my kr xeminer: On the basis of examir and manner stated.					
		To the comp	Σ	29b. Signature and title of certifier		-	9c. License number	29d	d. Date signed (Mont	th, Day, Year)
		Li			11.		143725		8/19	105
		1)		30. Name and address of person w	tho completed cause of death (Ite	em 23a) (Type, Print)			7.7	
		10		DR. TARIQ MAH		NEY VALLEY	RD. TIMONIU	M, MD 2109	3	
		St Regis	tate	31. Date filed (Month, Day, Year)	2005 32. Pegistrar's Sign	nature Signature				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrer	State of Ma	aryland		artment of rtificate of		Mental H	ygiene Reg. N2. 0 1	0.5	27505
İ	Physic /Medi		Decedent's Name (First, Middle, Last, Voh 0)			Carne	obell.	2. Date of D Month		Year 2005	3. Time of Death
	Examir Funeral		5. Social Security Number 6. Se	<in5 hos<br="">x 7. Ag</in5>	pita e (In yrs. la	st birthday)	4b. City, Town, Bultin If Under 1 Yea Months Days		s. 8. Date of B	N/A	9. Birth	olace (State or Foreign
· de j	Director		Usual Residence of Decedent	M 2□F	65	Yrs.		Hours Mil		11,1939	Penns	sylvania
	the Marylan 28a-f show	ctor	DE Sussex			Town or Lo n View	ocation				1	1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 108 Naomi Drive				10f. Zip Code 19970-	0624		10g. Citizen of		ntry?
36	72 hours after death with the Maryland "natural", or Items 23c or 28a-f show idical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1\(\sum Yes 2 \subseteq 1\) If Yes, Give			Was Decedent of	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or Norto Rican, etc.)	U.S lo- 14. Ra Bla Speci	ice - Americ ack, White,	etc.
21215-0036	C 2 53	Completed b	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	5+)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of 8	Business/In	nite _{dustry}
	2 should be filed within and Mental Hygiene. Is marked other then "eumatic event, the Me	Be	17. Father's Name (First, Middle, Last) Joseph Campbell	4			Manager	18. Mother's Na Kathryi	ame (First, Middle n Stash	Cas e, Maiden Suma		
Maryland	ges 1 and 2 should be it of Health and Mental if item 27 is marked or or other treumatic eve	To	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (Stree	t and Number or F		ber, City or Town	, State, Zip	Code)
	1 and Health em 27 ther tr		Janette H. Campbell - Wi	ife	20b. Pla		aomi Drive sition (Name of	Ocean View	w, Delawar	e 19970-9		um Ctata
Baltimore,	nit. Pages artment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ P `4 ☐ Donation 5 ☑ Other (Specify)	lemoval from State	Cel	metery, crer	matory or other pla Mausoleum	h 40 m				Pennsylvania
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	Heathe	er Cain	1 22 530	Name and Addr D5 Harford	ess of Facility Le Road Balt	eonard J. imore, Mar	Ruck, Inc yland 212	•	Cilisy Ivallia
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Duo deno	n Res a conseque	ance of):	er the mode of dy		ocaroliti			Approximate Interval Between Onset and Death 4-months
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as de la de					- ,			
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	death 3	Ectopic pregnand Other (specify)	у			ate of delive	ry Day Year
۵.	sign d be	by	Part II. Other significant conditions cor	ntributing to death bu	ut not result	ting in the u	nderlying cause gi	ven in Part I.		tobacco use con	tribute to th	e cause of death?
al Records,	The law ate has b page 2 s	Completed							24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	prior to con death?	osy findings available npletion of cause of
f Vital	S S	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2 🗆 EI	R/Outpatien	t 3 DOA Ot	200	ath Check onl		ner /Snecify	•}
Division of	ding h. After fune	ertification: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	у 2	8b. Time of Injury	28c. Inju	rv at	,	how injury occur		,
Divi	el or Attend s after death if Director: , id in by the f	Sertifi	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At hom :. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	oer or Rural	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Sunerel Director: After completely filled in by the fune	edical C	29a. Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Examin	and manner sta	examinatio ted.	in and/or inv	estigation, in my	opinion, death occ	urred at the time,	date and place,	and due to	the cause(s)
	To the within comp	Ž	29b. Signature and title of certifier	\searrow			29c. Licen	se number		29d. Date signe	d (Month, E	ay, Year)
•			30. Name and address o person who co	mpleted cause of de	m.I)	Re	5-000		August	20,2	1005
1	57		Mustopha School Th	Tohns Ho	thins /	Lay (Type, I	1,600 N	th wolfe S	treet Both	more No	lacylar	121287
	Sta Registr	- 100	31. Date filed (Month, Day, Year) AUG 2 3 2	32. A stra	r's Signatui	& A	berte	TENSING THE STATE		- Alkins (File Block)	0	0ay, Year) 2005 NJ 21287

			1 - For State Registrar	State of Ma	arylan		artmen rtificat			ınd M	, ,	jiene	n 5	27506
	Physici /Medic		1. Decedent's Name (First, Middle John	william	Carm	nody					2. Date of Dea Month August	_	20055"	3. Time of beath 12:25 💆
	Examin		4a. Facility Name (If not institution Manor Care-	Towson			T	וםפשם					nty of Deatl	re
	Funeral Director		5. Social Security Number 215-09-5663 Usual Residence of Decedent	6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e (In yrs. I. 85	ast birthday Yrs.	Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth July 21	, ^v °1/920	9. Bird Mai	nplace (State or Foreign untay) YIand
	e Maryland 8s-f show	Director	MD 10b. County	/a		,Town or L Baltim								10d. Inside City Limits 1 X Yes 2 □ No
	with th		10e. Street and Number 6002 Burgess Av	/enue			10f. Zip	Code 21 21 4			1	10g. Citizen ∈		untry?
036	in 72 hours after death with the Maryland 1 "natural", or Items 23a or 28a-f show Polical Examiner must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent 8 Armed Forces?		S. 13.		dent of Hi offy Cubar		gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Ame	ncan Indian, o, etc.
Maryland 21215-0036	72	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12	t's Education at grade completed) College (1-4or 5	+)	(Giv. life.	edent's Usua e kind of wo DO NOT us ket []	rk done d se retired,	urina most	of worki	ing	16b. Kind of	Business/I	ndustry
yland	nd 2 should be filed within and Mental Hygiene. 27 Is marked other then "r traumatic event, It a Mes	To Be (17. Father's Name (First, Middle, William		Carmo	dy			18. Mothe) (First, Middle, i	_	ame) I rk e	
Baltimore, Mar	Pages 1 and nent of Heamant: If Item		19a. Informant's Name/Relations Alice A. Carmo 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S)	ody-wife 3 Removal from State	Par	600 lace of Disp emetery, cre kwood	2 Burg cosition (Nar comatory or o Ceme	gess ne of ther place tery	Aven	ue, 8/2	3/05	re, MD 20c. Locatio Bal	212 n-City or timor	Town, State
E E	permit. Depart Import any inj		21. Signature of Funeral Service 23a. Part1. Enter the disease, or			5	305 H	arfo	rd Rd	., В	altimore	e, MD	Inc. 2121	Funeral Hom
8/60,	Physician /Medical Examiner and physician and physician and physician and the partial functions it is the partial function and physician and p	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the cause of	a Due to (or as a d	a consequal consequal	uence of):								Interval Batwaen Onsat and Death Yeary's
.O. Box 6	The law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	□Ectopic pr □ Other (sp						Date of deli Month	very Day Year
٦.	w requires that been signed b should be deta	by	Part II. Other significant condition Oropharyng	ons contributing to death but			underlying c	ause give	n in Part I.			bacco use co		the cause of death?
Vital Records,		e Completed	25. Was case referred to medical								24a. Was a autops perforr	med? 2 2 No	b. Were au prior to death? 1 \(\text{Yes}	topsy findings available ompletion of cause of 22 No
DIVISION OF VII	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day gation		ER/Outpatie 28b. Time Injury	ont 3 DC	8c. Injury Work	r: 4.28 Nu	rsing Ho	n (Check only on me 5 ☐ Reside 28d. Describe ho	ence 6 🗆 C		ify)
DIXI	spital or Att ours after di neral Direct filled in by t		3 Suicide 6 Could determ 4 Homicide determ 29a. Centifier 1 Certifyin		c. (Specify	•)			e date an		City or Town	n, State)		ral Route Number,
	the Ho. hin 24 h the Fur npletely	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examinat	ion and/or i	nvestigation	, in my op	inion, deat	h occurr	ed at the time, d	ate and plac	e, and due	to the cause(s)
,	To To	M	29b. Signature and title of certifie	Sael in	()			. License	6 11 9	9		19d. Date sig Aug,		2005
1	57		30. Name and address of person Jason 13/ac					Suit	e 20	3, '	Touson,	MD	2120)4
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signat	ture	Societa							1

	1	For State Registrar		State of	Marylar				ealth a D <i>eath</i>			giene Reg. NO	വാട	27507
		1. Decedent's Name (First,	Middle, Last)						1	2. Date of De Month	ath Cay	Yea	3. Time of beatt
Physicia /Medic		Leon		Co1	eman,	Sr						st 18,		
Examin		a. Facility Name (If not ins	titution, give	street and nun	nber)		4b. City	Town, or	Location	of Death		4c. Co	ounty of De	eath
	3	Prince George	's Ho	spital			Chev					Pri	nce (George's
Funeral		5. Social Security Number	6. Se	x M 2□F	7. Age (In yrs. 64		If Unde Months	r 1 Year Days	If Under Hours		8. Date of Bir Month, 20	th Y, Year o /	9. 8	Birthplace (State or Foreign Country)
Director		578-52-3659		3M 2LIF		Yrs.				J	une 20	, 154	Wa	ashington, DC
pu *	+	Usual Residence of Deced 10a. State 10b. (ounty		10c. Gi	ty, Town or Lo	cation							10d. Inside City Limits
aryla sho	۱		•	eorge's		itol H		e						1 ∰ Yes 2 □ No
Ne M	Director	10e. Street and Number		20180	оцр	TCOT III						10g. Citize	4 14/h -4	0
vith to	늗							Code				•		•
ath v	a	616 Hedge	eat A	Avenue	deat Constal	10	_	0743	inneria Ori	:=:=2 /C===	it. Van as Na	Unite		ates merican Indian,
er de Itema	Funeral	11. Marital Status	7.14	12. Was Dece	rces?		f Yes, spe	cify Cuba	in, Mexicar	n, Puerto R	ify Yes or No ican, etc.)	- 1	Black, W	
and ZIZIS-UUSO be filed within 72 hours after death with the Maryland ntal Hygiene. do other then "neturel; or items 23a or 28e-f show event, the Medical Exertified at	by F	1 Never Married 2		If Yes, Giv Year or D	2 □ No 19 (eates: 19 (1 🗆 Yes	2 X No	Specify:			S	pecify:	Black
P in E			cedent's Edu		19	16a. Dece	dent's Usu	al Occupa	ation			16b Kind	of Busine	ss/Industry
n 72	Completed	(Specify only	highest grad	le completed)		(Give		ork done d	during mos	st of working	g			,
Z1Z15-UU36 di within 72 hours afl gione. er then "neturel", or the Medical Eurol	E	Elementary/Secondary (_{i-12)}	College (1	-4or 5+)	Ment:	1 He	alth	Coup	selor		Ноз	1th (⁷ ara
nd Z IZ I e filed within al Hygiene. I other then vent, the Ma		17. Father's Name (First, A	iddle, Last)			1101100		u L CII			(First, Middle			Jaj.C
d be ental	To Be	George H. I	avne						Jann	ie Mi	tche11			
2 should be to and Mental I is marked of eumatic eve	F	19a. Informant's Name/Re		ype, Print)		19b. Maili	ng Addres	s (Street a			Route Numb		own, State	e, Zip Code)
Maryland td 2 should be file th and Mental Hy t7 is marked oth treumatic event		Earnestine (o1emai	n		616	Hedg	eleai	f Ave	. Ca	pitol	Heigh	ts, N	D 20743
IOCE, Maryldges 1 and 2 should at 0 Health and Mer if item 27 is marke or other treumatic	- 1	20a. Method of Disposition			20b.	Place of Dispo	sition (Na	me of	-1	Da	ite			or Town, State
Pages nent of hant: if its		Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O			State Fo	cemetery creater Lind	oln	Ceme	tery	8/25/	2005	Brent	wood,	, MD
BAILIMOFE, permit. Pages 1 at Department of Hea importent: if item any injury or othe	ĺ	21. Signature of Fund al S			1						Linco			
		Jario /	to	1'-									d, MI	20772
n		23a. Part1. Enter the dise shock, or heart failur	se, or comp List only o	lications that cone cause on e	aused the dea ach line.	th. Do not en	er the mo	de of dyin	g, such as	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition		FATA	42 C	ARDI.	4c	AX	CR144	THM	1/A			Onset and Death
/Medical		resulting in death)		Due to	or as a conse	quence of):								
Examiner		Sequentially list conditions		b										
D ≅	Examiner	cause. Enter Underlying Cause (Disease or injury		Due to	or as a cons	uence of								/
ecute ind trans	ше	Cause (Disease or injury that initiated events resulting in death) Last		с.										
e exe	Ä	resulting in death) case		Due to	or as a conse	quence of):								
cate be executed physicien and the burial-transit	dicai			d										
ntific ing pl		IF FEMALE:												
death certific	Physician/M	23b. Was decedent pregn in the past 12 month:	aria	23c. If yes, out 1 ☐Live b	come of pregn inth 2 Fet		Ectopic p	regnancy	,			23	d. Date of o	delivery Day Year
	2	1 ☐ Yes 2 🕱 No	·	4☐Pregn 9☐ Unkno	ant at time of	death 5[Other (s	pecify)		<u>-</u>			10101111	24)
that the de led by the a	Phy	9 ☐ Unknown \									no- pid			- 4- 4b
v & 9 9	þ	Part II. Other significant of	onditions co	intributing to de	ath but not re	sulting in the u	nderlying	cause give	en in Part I	I.				e to the cause of death? Probably 4 Vunknown
requir been si should	ted										1	Yes 2	NO 3	Probably 4 DOTKHOWN
Hecord he law requir e has been si age 2 should	Completed										24a. Was			autopsy findings available to completion of cause of
The I	E O											ormed?	death 1 🔲 Y	1?
	BeC	25. Was case referred to	nedical						26. Place	e of Death	(Check only			
_ % v =	ToE	examiner? 1 🗌 Yes2 📉 No		Hospital: 1 🔲 I	npatient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4 🗆 Nu	ursing Hom	e 5 🗆 Resi	idence 6 []Other (S	(pecify)
		27. Manner of Death		28a. Date	of Injury	28b. Time o	f	28c. Injun Worl	y at k?	2	8d. Describe	how injury	occurred	
ISION Attendin death. ctor: Aff y the fur	atio		Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, ,	,,	М		Yes 2	No				
DIVISION I or Attending after death. Director: Afte	€	3 Suicide 6 4 Homicide	Could not be determined	286. Place	of Injury - At I	nome, farm, st	reet, facto	y, office		2		Street and i	Vumber or	Rural Route Number,
Saffe Din	Certification:			Juidi										
UNISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attentions of the funerel or the fu	Medical (29a. Certifier 1 C (Check only one) 2 M	rtifying Phy dical Exam	rsician: To the	asis of examin	owledge, deal ation and/or in	h occurred vestigatio	at the tin	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) and p	nd manner lace, and c	as stated. due to the cause(s)
thin 2 the mple	Mec	29b. Signature and title of	certifier ~	and man	ner stated.		20	c. Licens	e number		Т	29d, Date	signed (Ma	onth, Day, Year)
, w T &		Los. Digitatoro and title of	· · ·	1/4	terne	MA				740		AD	6 11	2005
(1)		/			-~	1.00		/*1/	01	70		,	- 18	
111/	2	30. Name and address of	erson who c	4 . 1 .	e of death (Ite	m 23a) (Type,	Print)	40	/ Δν	740 E #	200	WAS	WING	JON Dr
		DR EDUARDA	Your!	1LANO	egistrár's Sign	328 C	JULL 19	ICAN	/ TW	0	פטכ	FALL) 20
Sta Registr	1	31. Date filed (Month, Day	NUG 2	3 2005	egistear's Sign		650	ALL!						

		•	For State		State of	of Mar			artment of H		d Menta		ene g. No2	005	27508
			Registrar 1. Decedent's Name (First, Mic	idle Las	st)	-		001	incate or E		2. Da	e of Death)	000	3. Time of Death
	Physicia	an				1						nth 18,	200	Year 5	7:00 A M
	/Medic		Dr. Kay Rol 4a. Facility Name (If not institu						4b. City, Town, or	Location of Do		. 10,		ounty of Death	7.00 A
•	Examin	er	23 Sunnyview			-011			Phoe	niv				Balti	imore
	Funeral		5. Social Security Number	6. S		7. Age (In yrs. last bir	thday)	If Under 1 Year	If Under 24 I	Hrs. 8. Dat	te of Birth	Vear	9. Birth	place (State or Foreign ntry)
	Director		529-20-1371	1	M 2□F		84	Yrs.	Months Days	Hours N	Jui	ne 23	, 19	21	ID
	P .		Usual Residence of Decedent 10a, State 10b, Cour			1	0c. City, Tow	n or Lo	cation						10d. Inside City Limits
	ehow	2				'	·								1 ☐ Yes 2X No
	Ba-f	ecto	MD B	alti	more		Phoe	nix	10f. Zip Code			10	a Citize	n of What Cou	ntry?
	with t	Funeral Director		D.,						2.1					,
	eath	era	23 Sunnyview 11. Marital Status	Dr.	12. Was Dec	cedent Ev	er in U.S.	13.1	Was Decedent of Hi	spanic Origin	? (Specify Ye	es or No-	14	USA . Race - Ameri	
	fter d r Itam iner	F	1 Never Married 2 1 N	arried	Armed F	orces? 2 No live			f Yes, specify Cuba		uerto Rican,	etc.)		Black, White,	
2	urs a	þ	3 ☐ Widowed 4 ☐ Divord		If Yes, G Year or	ive Dates:			1 ☐ Yes 2X No	Specify:			S	pecify: Whi	Lte
2-0030	72 hours after death with the Maryland Instural; or Itama 23a or 28a-f ehow Isal Examiner must be notified at	Completed	15. Deced)	16a	Dece	dent's Usual Occupa	ation during most of	working	1	6b. Kind	of Business/In	ndustry
7	thin 7	npie	Elementary/Secondary (0-1)		College	(1-4or 5+)		life.	DO NOT use retired)					
7	ygien ygien Yer th	Cou			5-	+		Psy	chiatrist	18. Mother's	Nama /First	Middle N		edical	
and	tal H d oth	Be	17. Father's Name (First, Midd Harold Cutle		,						Robins		TAIUGIT SE	umane)	
200	1 Mer narke	^L	19a. Informant's Name/Relation		Tima Print!		104	Mailie	ng Address (Street a				City or 7	Town State Zi	n Code)
Mar	d 2 sl th and 7 ls r traur						1 3	33 32							
o,	1 and Heall am 2 athar		Wyona B. Cut1 20a. Method of Disposition	2 <u> </u>	ire		20b. Place o	f Dispo	unnyview sition (Name of		hoeni:	2		ation - City or T	own, State
2	ages ant of it: If if		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other			n State	Mt. (Comf	matory or other place	<i>o</i> ⁄ ∤ Au	ig. 22 200	2	Ale	xandria	a. VA
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itams 23a or 28a-f show amy injury or other traumatic event, the Marical Examiner mast be notified at ance.		21. Signaturo a un rea sorv				Crema	22	2. Name and Address mmon Fune	s of Facility					
ñ	Depa Impo any in				1 J. F.	lagle	į	Lе 10	mmon Fune W. Pador	eral Ho nia Roa	ome of ad Tir	Dula: noniu	ney m. M	valley, D 21093	Inc.
			23a. Part1. Enter the disease shock, or heart failure.	, or com	plications that	caused the	ne death. Do	not ent	ter the mode of dyin	g, such as car	rdiac or resp	ratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		3	S	TRO	KE	3						Onset and Death
	/Medical Examiner		resulting in death)		Due to	o (or as a	consequence	of):							
	LAditille	_	Sequentially list conditions, if any leading to immediate	-	b. Due to	0 (or as a	consequence	of):							
	pet Insit	nine	Cause (Disease or injury	~	500 11	0 (01 43 4	5511354351105	01).							
<u>,</u>	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last		C. Due to	o (or as a	consequence	of):							
8760	ate be shysicia the bur	dicai			d										
9	tifical ng phy as th	Medi	IE EENALE.					_							
Box	death certific e attending p ed for use as l	an/N	IF FEMALE: 23b. Was decedent pregnant	- 1	23c. If yes, o 1☐Live		pregnancy Fetal deat	n 3[☐Ectopic pregnancy				23	Bd. Date of deliver Month	very Day Year
	0 0	Physician/Me	in the past 12 months? 1 Yes 2 No		4□Pre 9□Unk		me of death	5 [Other (specify)					17131111	
<u>Ч</u>	res that the de signed by the a be detached t	Phy	9 Unknown Part II. Other significant con	ditions	contributing to	death but	not resulting	in the I	inderlying cause div	en in Part I	2	3e. Did tob	acco use	e contribute to	the cause of death?
ŝ	res the signer	b	Part II. Other significant con	21110113	continuouing to	doain out	not resulting	11110	and only my daddo giv	on at 1 at 1.		1 □ Ye		/	
0.0	w require been si should t	etec									— III	4a. Wasaı	, · ·	24h Ware aut	topsy findings available
Division of Vital Records,	The law requires that the tte has been signed by th bage 2 should be detache	Completed								<u> </u>	_	autops: perforn	y ned?	prior to death?	ompletion of cause of
a			25. Was case referred to me	tion	T					OC Disease	f Death (Che		NO	1 ☐ Yes	26 No
₹	sicia certi irecto	o Be	examiner?	ircali	Hospital:] Inpatien	t 2 🗆 ER/O	utnatie	nt 3 DOA Oth	or	ing Home			☐Other (Spec	ify)
ō	ttanding Physician: The lav Beath, tor: After this certificate has the funeral director, page 2.	n: To	27. Manner of Death			te of Injury		Time o		y at	-	escribe ho			,,
on	nding ath. r: Afte e fun	ation	1 Natural 5 □ Pe 2 □ Accident inv	nding estigatio		ontn, Day	rear)	Injury		K? Yes 2 □ No					
VIS	or Attanafter deat Director: in by the	Certification:		uld not b termined	28e. Pla	ce of Injur Iding, etc.	y - At home, f	arm, st	reet, factory, office			ocation (St		Number or Rui	ral Route Number,
	tal or	Cer				J.					1				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director.	edical	(Check only 2 Mad		miner: On the	basis of e	examination a		th occurred at the tirnvestigation, in my o						
	thin 2 the mple	Med	one) 29b. Signature and title of pe	tifiar	and ma	anner state	BG.		29c. Licens	e number		2	9d. Date	signed (Month	n, Day, Year)
)	1 2 1 8		PR M	P	5	WY			Di	3686	16	K	110011	J18.	2005
	CIX		30. Name and address of per	son wb	completed ca	use of de	ath (Item 23a)	(Type	Print)	/	-1	/	। जानुज	31 1)	000
	41		BERNARO I	FR	AV. TZ	-m.6	1 560		LOCH RAV	EN BI	VA. To	08-17	BAI	Timere	2005 FMD21239
	St	ate	31. Date filed (Month, Day, Y		32.	. Registra	r's Signature	-	of 0						
154	Regist	rar	AUG 2 3	2005	ANGE	A.	r's Signature								
m.	18411.47.0	100	11000		400		-								

ORIGINAL

			State of Maryland / Dep	artment of Health and N		0000	27510					
			Registrer 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg.	No. U U U	3. Time of Death					
	Physicia	an	Kenneth Leo Chatelaine		Month August 1	Day Year	11:58 P ^M					
	/Medic		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 1	4c. County of Deat						
	Examin	er	359 Gatewater Court	Glen Burnie		Anne Arı						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt						
	Director		473-28-6367 ¹ X [™] ^{2□} F 71 Yrs.	Months Days Hours Min.	10/16/19	31 MN	hplace (State or Foreign untry)					
	PC .		Usual Residence of Decedent									
	anyla ehov	_	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
	he M	ecto		Glen Burnie	1.40-	. Citizen of What Co	21.					
	with t	ä	10e. Street and Number 359 Gatewater Court	10f. Zip Code 21060	109	U.S.A.	ountry?					
	ea 23	eral			ecity Ves or No-	14. Race - Ame	rican Indian					
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or Itema 23a or 28a-f ehow aumatic event, the Medical Exammer retirual be notified at	Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.					
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213-0030	72 ho	Completed		edent's Usual Occupation a kind of work done during most of work	16	b. Kind of Business/	Industry					
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V	ed wygier ygier ner th	Sor		Professor		Educatio	n					
ana	0 = 0 5	Be	17. Father's Name (First, Middle, Last) Frank Chatelaine		e (First, Middle, Ma	iden Sumame)						
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	artme ortan injur					Funeral						
ä	permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked any injury or other traumatic en		W (2013/9)	1 Second Avenue S	-							
			23a. Part 1. Enter the disease, or complications hat caused the death. Do not el				Approximate Interval Between					
	Physician	8 11	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition END STACE RE	NAT DISCASS			Onset and Death					
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	, J.J.,			3 TEADS					
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	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	iverv					
POX	death atter	clar	in the past 12 months? 1 Vac 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year					
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ώ T	requires that the deben signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?					
cords	en sig	ed t	CORD MARY ATTURY DISERSE		1 🗆 Yes	2 X No 3 □ Pr	obably 4 Unknown					
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r	The ste h	mo:			performe	d? death?	2 ™ No					
Vital	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		h (Check only one)							
0	sic dii	²	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient				cify)					
	iding Phyaician: th. : After this certifice funeral director, p	lon:	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred						
2	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be 388 Place of Injury At home farm of	M 1 Yes 2 No	28f Location (Street	et and Number or Ru	iral Bouta Number					
UIVISION	or A after Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, S		arai riodio iguinooi,					
	To the Hoepital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the caus	se(s) and manner as	stated.					
	ne Ho ne Fu ne Fu	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)					
	withi To th	ž	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Monta	h, Day, Year)					
	1		MD	00058864		8/22/0	25-					
	15		30. Name and address of person who completed cause of death (Item 23a) (Type									
			31. Date filed (Month, Day, Year) 32. Parar's Signature	US RD LUTTU	EVILLE, M	10 2100	1 5					
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 3 2005 32. Protein's Signature AUG 2 3 2005									

		1 - For State Registrar	State of Maryland	•	rtment of He tificate of D		Mental Hy	giene	05 27511
Physic /Med Exami	cai	Decedent's Name (First, Middle, Last) A St A Fecility Name (If not institution, give str		CHE	SLEY 4b. Gity, Town, or			Day	Year S. Time of Death
Funeral Director		NA NA	AZ CONTE 7. Age (In yrs. Ias	st birthday) _ Yrs.	If Under 1 Year Months Days 9	If Under 24 Hrs Hours Min.		15 Y by, Yeer) 0005	9. Birthplece (State or Foreign Maryland
h the Maryland r 28a-f ehow	irector	Usuel Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number	10c. City,	Town or Loc	ation imore 10f. Zip Code			10g. Citizen of	10d. Inside City Limits 1 1 Yes 2 □ No What Country?
be filed within 72 hours after death with the Maryland lal Hygiene. Id other than "netural", or Items 23a or 28a-f show event, the Medical Exercities in usable notified at	by Funeral Director	911 Pennsylvania Avenu 11. Marital Status 1 N Never Married 2 Married 3 Widowed 4 Divorced	e Apt 3B Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	21.2 As Decedent of His Yes, specify Cubar ☐ Yes 2 1 No	201 spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.))- 14. Rac	USA ce - American Indian, ck, White, etc. Black
iled within 72 hours af lygiene. her than "netural", or nt, the wedter Ere in	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) NA 17. Father's Name (First, Middle, Last)		(Give F	ent's Usual Occupa ind of work done d O NOT use retired) NA	uring most of wo	rking me (First, Middle		Susiness/Industry NA
and Mer and Mer is marks	To Be	Keith Chesley 19a. Informant's Name/Relationship (Type Sophia DeMar/ Mother	a, Print)		n Address (Street a	Soph and Number or R	ia DeMar ural Route Numb	er, City or Town	, State, Zip Code)
it. Partmentrant:		20a. Method of Disposition 1 X Burial 2 Cremation 3 Rei 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	moval from State Mt. Z	ce of Dispos metery, crem Lion Cen	ition (Name of atory or other place	8-2	Date 2-05		- City or Town, State
Physician /Medical		23a. Part 1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ations that caused the death. cause on each line. Due to (or as a conseque	Do not enter ME ence of):		, such as cardia		rrest,	Approximate Interval Between Ons an Death
vician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque	ence of):	ENIN SRY D	16 M	S =355	YNDL	ome 9d
the death certify the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 D No 9 ☐ Unknown	c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 🗔	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
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To the Hoepital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	To Be	27. Manner of Death		R/Outpatient 28b. Time of Injury	3□ DOA Othe	^{Ir:} 4 □ Nursing I at	1 X Yes ath (Check only dome 5 ☐ Resi	2□No one)	
To the Hoepital or Attendir within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certification;	1 Atural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	M 1 ☐ Y et, factory, office	′es 2 □ No	City or To	wn, State)	ber or Rural Route Number,
To the Hoepi within 24 hou To the Funer completely fill	Medical	29a. Certifier (Check only Medical Examine one) 29b. Signature and title of certifier	cian: To the best of my knower: On the basis of examination and manner stated.	on and/or inv	29c. License	number	urred at the time,	29d. Date signe	and due to the cause(s) ed (Month, Day, Year)
3		30. Name and address of person who com	1	23a) (Type, F	11-0 PAUL PL	0439	BALTI	MOVE,	T17, 2005 MD 21202
Si Regis DHMH 17 Rev 1/		31. Date filed (Month, Day, Year) AUG 2 3 2005	32. Registrar's Signatu	Span	W				

DHMH 17 Rev 1/2001

05-05258

Lamoni RJD	ca Doug	;la	S For State Registrar	State of Marylar		artment of			giene	305	07616
	<u> </u>	:O-	1. Decedent's Name (First, Middle, Las					2. Date of Dea	ath	J (J -)	3. Fine of Death Z
	Physic /Medi		La'Monica	Douglas					4 ^{Day} 200		1348P. M
	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, Baltim	or Location of Deatl	h	4c. County	of Death	
	Funcial		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	r If Under 24 Hrs.		h	·	lace (State or Foreign
	Funeral Director		N/A	□ M 21XF	Yrs.	Months Days	Hours Min.	July 20	, Year) 0, 2005	Mary	land
	р ,		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	postion		*			0d. Inside City Limits
	farylan show	ŏ								'	1 ☐ Yes 2 X No
	the Maryla 28a-f shor	rect	MD Anne Ar 10e. Street and Number	unde! GI6	en Burr	10f. Zip Code			10g. Citizen of	What Coun	itry?
	th with 23a or ust be	i Di	1012 Somerset Dri	ve		21061			USA		
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	I.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Rad	e - Americ	
36	s after	by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give		1 ☐ Yes 2X No			ł	Blac	
21215-0036	hour		15, Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occu	upation		16b. Kind of B	usiness/Ind	dustry
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21	filed within 72 hours after death with the Maryland Hygiene. "naturel", or Items 23a or 28a-f show pit, the Medical Examinat must be notitled at	Completed	0			Infant			never		ed
pue	be fill d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Suman	ne)	
Maryland	2 should be and Mental is marked of aumatic eve	P	UNKNOWN 19a. Informant's Name/Relationship (7)	Type Print)	19b Maili	na Address (Stree	Arkia [r City or Town	State Zin	Code
Ma	es 1 and 2 should be filed of Health and Mental Hygis I fem 27 is marked other rother traumatic event, I		Arkia Douglas	ypo,y			t Drive, 0				
Ē,	s 1 ar		20a. Method of Disposition	20b.		sition (Name of matory or other pla		Date	20c. Location -		
<u>ii</u>	Page nent c ant: If ury or		1 ☐ Burial 2 🖰 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	tro Cre			. 22	Baltimo	ore. I	MD
Saltimore,	permit. Pages Department of h Important: If Ite any injury or of		21. Signature of Funeral Service Ucen		22	2. Name and Addr	ress of Facility Sta	allings F	uneral	Home	, PA
	6 5 2 0 5		Muschell /	Halteres	ار 31	11 Mount	cain Rd. F	Pasadena,	, MD 211	122	
	Physician /Medical Examiner		23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	nt fex		a to the	1 1			Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as a consec	quence of):						
8760,	sate be executed obysician and the burial-transit	dicai Examine	that initiated events resulting in death) Last	cDue to (or as a consected	quence of):						
P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3[Ectopic pregnand Other (specify)	су			te of delive	ry Day Year
٥,	s that the sine of by the detaction	by Pr	Part II. Dther significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
rds	w requires been sign should be							1 🗆 Y	es 2 No	3 🗌 Prob	ably 4 □Unknown
ecc	as be	Completed						24a. Was a	sv	prior to con	psy findings available impletion of cause of
<u>~</u>	: The cate ha	Con						, perfor	med? 2 🗆 No	death?	2□ No
Vits.	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner? 1 △ Yes 2 □ No	Hospital:		_ [0	thor	ath (Check only or			
4	Phys r this rat dii	7: 70	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	IL SEL DOA	4 🗆 Nursing 🗅	lome 5 Resid			
Division of Vital Records,	tending Ph leath. tor: After th	Certification:	1 □Natural 5 □ Pending 2 □ Accident investigation		Rund 5:0	200	ork? ⊒Yes 2∭TNo	0	saulta	dec	eased uses
ivis	r Atte er de recto	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci)	28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	Route Number,
۵	ital o				residenc	e		gun Bur	me, mo		, 01-
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	time, date and place opinion, death occu	, and due to the c	ause(s) and ma	anner as st and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Hosell nin			M.E.		29d. Date signe August 6		
			30. Name and address of person who of	completed cause of death (Item	m 23a) (Type,		Penn Stree	et. Balti	imore. N	Marvl:	and 21201
*	St	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Sign	ature	A				J	
	Regist		AUC237	2005	J. 1	Carle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Mo. Jent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:00pm **Physician** 5 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ke 7. Age (In yrs. last) 6. Sex Birthplace (State or Foreign
 Country) Funeral 124 2 F Director Vorth (arolin the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes No ☐ Never Married 2☐ Married 1 ☐ Yes 2 ☐ 0 Baltimore, Maryland 21215-0036 Specify: Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) y/pecondury (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) s Name (First, Middle, Last) Be 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau e0b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eumonia **Physician** piration /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ sphagia lar 1 Yes 2 No 3 Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Division the Hospital or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 0 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

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3 2005

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32 degistrar's Signature

			a FOI	partment of Health and Mertificate of Death	ental Hygien	2005 0751	1.
	°O		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	
	Physicia /Medic		Robert Deleon			8 205 9.40 P.M.	/м
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death	
			Manor Care Ruxton 5. Social Security Number 6. Sex 7. Age (In vrs. last birtho	Towson If Under 1 Year If Under 24 Hrs.		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2 □ F 7. Age (In yrs. last birthd 212-05-0748 7. Age (In yrs. last birthd 87 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Year, July 18, 1	9. Birthplace (State or Forei Country) 918 MD	sign
			Usual Residence of Decedent		July 10, 1	910 MD	
	show	_	10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limi	
	8a-1 s	ecto		eysville			NO
	with ti	Funeral Director	100. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?	
	eath rust	eral	10205 Sunny Lake Place Apt. E 11. Marital Status 12. Was Decedent Ever in U.S.	21030 3 Was Decedent of Hispanic Origin? (Spe	ocity Yes or No.	USA 14. Race - American Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygene. Item 27 is marked other then "neturel; or items 23e or 28e-1 show other treumatic event, if a Modical Examinar must be notified at	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 M No 1 Yes, Give 1 Year or Dates:	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 X No Specify: 	Rican, etc.)	Black, White, etc. Specify: White	
21215-0036	should be filed within 72 hours nd Mental Hygiene. marked other then "neturel;" imatic event, the Midical Exa	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b. F	Kind of Business/Industry	
215	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working. DO NOT use retired)	ng		
	led w lygien her th			urniture Salesman	_	Furniture	
Maryland	ntal H ed ot	Be	17. Father's Name (First, Middle, Last) Robert E. DeLeon		(First, Middle, Maider an Mirowit	<i>'</i>	
Ž	should and Men is marke sumatic	To		ailing Address (Street and Number or Rura			
	1 and 2 : Health ar tem 27 is				herville,		
ore,	es 1 a of Hei litem rothe		20a. Method of Disposition 20b. Place of Di	rematory or other place) A	ate 20c. L	ocation - City or Town, State	
<u>Ĕ</u>	Pages nent of ant: If it ury or o		1 Bunal 2 MCremation 3 Hemoval from State Mt. Com Cremator	fort Aug. 2005	22,	Alexandria, VA	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other 2008.		21. Signature of Funesal Service Licensee Michael J. Flagle	22. Name and Address of Facility emmon Funeral Home 0 W. Padonia Road	of Dulaney	Valley, Inc. MD 21093	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one capite on each fine.	Approximate Interval Between			
	Pnysician		Immediate Cause (Final disease or condition	mive.		Onset and Death	
4	/Medical Examiner		resulting in death) Due to (or as a consequence of):	•			
		-	Sequentially list conditions, if any, leading to immediate b. Due to (/as a consequence of):	a			
V	uted I Insit	mine	Cause (Disease or injury				
64	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	that initiated events c. Due to (or as a consequence of):				
8760,	ite be iysicia ne bur	cal	d				
9	ing ph	Med	IF FEMALE:				
Вох	that the death certifica ed by the attending ph detached for use as th	jan/	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year	
Ö	he de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
Δ.	res that the signed by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?	
rds	quires n sign	ed by			1 ☐ Yes 2	No 3 Probably 4 Unknow	Wn
Records,	law requir as been si 2 should	Completed			24a. Was an	24b. Were autopsy findings availab	ble
Ä	i icien : The lav certificate has rector, page 2	Com			autopsy performed? 1 ☐ Yes 2 ☐ No	death?	JΓ
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death			
of \	di is	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		ne 5 Residence		
O	ding I h. After funer	tlon	27. Manner eath 1 atural 5 Pending (Month, Day Year) 2 Accident investigation		8d. Describe how inju	ry occurred	
Division of	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm,		8f. Location (Street ar	nd Number or Rural Route Number,	
Ö	s after al Direct	Certification:	4 Homicide Building, etc. (Specify)		City or Town, State		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check of yone) Certifying Physician: To the best of my knowledge, definition and/o and manner stated.	path occurred at the time, date and place, a rinvestigation, in my opinion, death occurred at the time, date and place, a rinvestigation, in my opinion, death occurred at the time, date and place, a rinvestigation, and the time, date and place, a rinvestigation, in my opinion, death occurred at the time, date and place, a rinvestigation, in my opinion, death occurred at the time, date and place, a rinvestigation, in my opinion, death occurred at the time, date and place, a rinvestigation, in my opinion, death occurred at the time, date and place, a rinvestigation, and the time, date and place, a rinvestigation, and the time, date and place, a rinvestigation, and the time, date and time, date and the time, date and the time, date and the time, date and time, date and time, date a	and due to the cause(s ad at the time, date and) and manner as stated. d place, and due to the cause(s)	
	To the Hi within 24 To the Fi complete	M	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)	
			MID	53593	81	17105.	
	10		30. Nam and address of person who completed cause of death (Item 23a) (Ty	De, Print) 7505 OSLENDING	re Suite à	,0 A.	
	F		31. Date filed (Month, Day, Year) 32. Registrar's signature	Towson 40 21	204		
	Sta Registr		ALIG 2. 3. 2005	rade			
DH	MH 17 Rev 1/20	001	HOGO S COOL ACTIONS IN THE				

DHMH 17 Rev 1/200

Registrar

AUG 2 3 2005

James Franklin 05-05564 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ינינט) -1	_	1- State Unpend Item 2:	State of M.	arylan 27,28	d / Depa Ba-f _C pe	artmen Tificate	t of H G84 ∌ <i>of L</i>	ealth a Death			-/-	105	275	16
	Physici	an	1. Decedent's Name (First, Middle, Last,								Date of Deat Month	th Eay	Year	9. Time of [Death
	/Medic		James	Frank							August	17	2005	1953	M
	Examin	er	4a. Facility Name (If not institution, give						Location of	of Death		N/A	nty of Death		
*	Funeval		Johns Hopkins Hospita 5. Social Security Number 6. Se		je (In yrs. I	last birthday)	If Under		ore If Under	24 Hrs.	8. Date of Birth			olace (State or	Foreign
	Funeral Director			M 2□F	48	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, NOVEMBER	6, 1956	Connec	Strcut_	
	Maryland a-f ahow	ctor	10a. State 10b. County Florida Brevard			r, Town or Lo	cation							10d. Inside City 1 ☐ Yes	
	3a or 28	il Director	10e. Street and Number 1215 Lake Drive				10f. Zip	Code 32922			1	0g. Citizen (of What Cou	ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itame 23s or 28s-f show simportant: If item 27 is marked other than "natural", or itame 23s or 28s-f show any figury or other traumatic avant, the Medical Examinar must be nutified at ance.	by Funeral	11. Marital Status 1XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Deced If Yes, spec	ify Cuba	spanic Ori n, Mexican Specify:	n, Puerto F	cify Yes or No- Rican, etc.)	В	lace - Ameni Black, White, cify: White	etc.	
21215-0036	within 72 ho ene. than "natur he wedical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		5+)	16a. Dece (Give life. Clerk	kind of woi DO NOT us	rk done a	furing mos	st of workin	ng .	16b. Kind of	Business/In	dustry	
Maryland 2	should be filed ind Mental Hygie marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Thomas F. Franklin								(First, Middle, I	Maiden Sum	ame)		
	and 2 sho eatth and n 27 is m		19a. tnformant's Name/Relationship (7) Thomas J. Franklin/Bro								Connectic			Code)	
Baltimore,	Pages 1 annual part of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	C. C.	lace of Dispo emetery, crei Itop Ser	natory or o	ther plac	e)	8/23			n-CityorTo n Maryl		
Balt	permit. Departr importe any inje		21. Signature of Funeral Service Licens	•• Christina	L. Hi	i1ton 22 Le 53	2. Name an conard 805 Har	d Addres J. Ru ford	s of Facilit ICK Ir Road	b Baltin	more Mary	land 2	21214		
	Physician /Medical	8 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that cause ne cause on each l Hanging Due to (or as	ine.		er the mod	e of dyin	g, such as	cardiac or	respiratory arr	est,	-	Approximate Interval Betw Onset and D	veen
8760,	cate be executed physicien and it the burial-transit	icai Examiner	if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	Due to (or as											
P.O. Box 68	Physician: The law requires that the death certificate be executed tribic certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pr Other (sp						Date of delive	•	ear
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Il Records,	ding Physician: The law re h. After this certificete has bee funeral director, page 2 sho	Completed									24a. Was a autops perform	sy .	prior to co death?	opsy findings a empletion of ca 2 No	vallable use of
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Division of Vital	or Attending siter death. Director: Aftel in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Inbuilding, e	jury - At ho	ome, farm, st	reet, factory	, office		2	Bif. Location (Si City or Town ntake	treet and Ny q, State) C	ent rati	II Route Jumb Book1	ng an
	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Example one)	sician: To the best iner: On the basis of	of my kno of examina	wledge, deat	h occurred	at the tim	ne, date an	nd place, a	ind due to the c	ause(s) and	manner as s	tated.	
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0	7		30. Name and address of person who c	AN				1 Per	n Stre	eet B	altimore,	Maryla	nd 2120)1	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 3 200		rar's Signa	ture	Les of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Na... ame (First, Middle, La 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give Examiner timore Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** 1 □ M 2(□)/= Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show ral', or Itams 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 76 Baltimore, Maryland 21215-0036 Specify: 3 Nidowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business/Industry The Medical other than dary (0-12) College (1-4or 5+) Sel 18. Mother's Name (First, Middle, Maiden (First, Middle, Last) 17. Father's Name and Mental is marked State, Zip Code) 21060 19b. Mailing Address Street and Number or Rural Route Number, City or Town ages 1 and 2
Lepartment of Health an Important: If item 27 is m any injury or other YNOR 20c. Location - City or Town, State 20b. Place of Disposition Date 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final ears demente Physician treadure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 000 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes ours after death.

Interest Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year, 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specity) within 24 hours a To the Funeral C To the Hospital in Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier august 17, 2005 013657

Registrar

State

700 W

32. Registrar's Signature

40 H STREET, BALTIMORE, OND 21211

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

THE GREGOR

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2005 AUGUST 21, **Physician** 8:15 P M **ODESSA** Η. FISHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE WOODHOLME ASSISTED LIVING CENTER PIKESVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12-22-1919 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2∰F Yrs 85 Director 212-18-3374 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryles Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, It a Madical Examination as Learnellind at N Yes 2 No Director PIKESVILLE MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 101 WOODHOLME AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PENTAGON 12 CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CATHERINE ROBERTSON ELMER HARRIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3007 WOLCOTT AVENUE, BALTIMORE, MD 21216 RICHARD HARRIS/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Magazian 2 ☐ Cremation 3 ☐ Removal from State 8-25-2005 BALTO., MD LOUDEN PARK CEM. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1) Her **Physician** (oronary disease or condition resulting in death) /Medical Due to (or as a consec Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, Examine ongestive Heart Jan attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, λq 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificete has 1 Yes 1 Yes 2 No or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTE Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 6 Other (Specify) 2 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending s after death.

I Director: Aft
of in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ro the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8-22-05 to completed cause of death (Item 23a) (Type, Print) MD 419 W Redword OUS J. Domen 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

			For State Registrar		aryland / Dep <i>Ce</i>	artment of F			eg. No 20	05	27519
	Physicia	an	1. Decedent's Name (First, Middle,		nanz			Month	Day	Year 2005	4:30 PM
	/Medic		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Deat	D8	4c. County	of Death	
	Examin	er	Nonthwest				Mstou		Bal	tim	one
	Funeral Director		212-48-8290	. Sex 7. Ag 1 M 2 ☐ F	ge (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth Month, Day 06/14/1	947	9. Birthplac Country	e (State or Foreign) MD
	and and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City Limits
	Mary -f sho	to	MD BA	_TIMORE	OWIN	GS MILLS					1 ☐ Yes 2 No
	h the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Country	?
	238 c	alD	12600 BONITA A	VENUE		2111			U.S		
21215-0036	72 hours after death with the Maryland Insturat; or Itams 23a or 28a-f show	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1	No.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - American k, White, etc WHI	·.
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Maryland	be d la	To Be	ROBERT 19a. Informant's Name/Relationship		10h Mail	FRANZ	PHYLLIS	5			MORAN
Ma	is a			BROTHER		COOLSPRIM					
	s 1 and if Health item 27 other tr		20a. Method of Disposition		20b. Place of Disp		1	Date	20c. Location -		
Ë	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		OHEB SHAL	-		2/2005 F	REISTERS	STOWN,	MD
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Li	censee	2	2. Name and Addre	ss of Facility SC	L LEVINS	ON & BR	OS., I	NC.
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause	d the death. Do not er					A	pproximate iterval Between
	Physician		Immediate Cause (Final disease or condition	•	enscler	sito	Cardia	vascul	ar Dis	0	nset and Death
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Records, P.	uires that the disignad by the disched	b	Part II. Other significant condition	s contributing to death I	but not resulting in the	underlying cause giv	ven in Part I.		bacco use conti es 2 \(\subseteq No		cause of death?
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Vital		a	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only or		10105 21	
N N	S 7	To B	examiner? 1 □ Yes 2 No	Hospital: 1 🗆 Inpati	ient 2 ER/Outpatie	ent 3 DOA Ott	ner: 4 🗆 Nursing I	Home 5 Resid	ence 6 🗆 Oth	er (Specify)	
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	o tha	Me	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signed	d (Month, Da	y, Year)
	r s r o		1 Jamile	yours	BO.	HOO	555644	4	08/10	7 200	55
	15		30. Name and address of person w				Randall	stown	MD 8	81133	
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 3 20	/32. Regist	trar's Signature	Est.					

		State of Maryland / I	Department of He Certificate of D		ntal Hygie Reg.		27520
		Decedent's Name (First, Middle, Last)	Ochtmodic of D		. Dete of Death		3. Time of Death
	Physician	MADISON M. FULWOOD SR.			Month AUGUST 1	9, 2005	6:40a
Jan .	/Medical Examiner	4e Fecility Name (If not institution, give street and number)	4b	. City, Town, or Loca	tion of Death	4c. County of Death	1
	Examiner	KESWICK NURSING CENTER		BALTIMO		N/a	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year Months Deys	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye	9. Birth	pplace (State or Foreign intry)
p)	Director	212-20-5878	113.		10–16–19	19 5001.	H CAROLINA
	land	10a. State 10b. County 10c. City, Tow					10d. Inside City Limits
	Many	MD. N/A BALT	rimore				1 X Yes 2 □ No
	vith the Mar or 28e-f sl be notitied Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of What Cou	untry?
	ath w	1523 N. MONROE ST.	21217	nania Origin? (Speci	ty Ves or No-	USA 14. Race - Amer	ican Indian.
120	be filed within 72 hours after death with the Maryland ital Hygiene. 4 other than *naturel', or items 23e or 28e-f show event, i'm Madical Examiner must be notified at sevent, i'm Madical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ri ☐ No 1 ☐ Yes 2♥ No Specify:				
9	2 hou		a. Decedent's Usual Occuper	tion uring most of working	16	b. Kind of Business/li	ndustry
215	e. na Nad	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	aning moot of woming			
21	ed within 72 hor ygiene. er then "nature it, the Medical Completed	-120-	LABORER	18. Mother's Name (First Middle Ma	RAILROAD	
and		17. Father's Neme (First, Middle, Last) JOHN W. FULWOOD		LELA CO		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Maryland 21215-0020	d 2 should the and Ment of 7 is marked traumatic		b. Mailing Address (Street a	nd Number or Rural i	Route Number, C	City or Town, State, Z	ip Code)
Z	nd 2 sulth ar allth ar 27 ia	CHRISTING KULWOOD (DAUGHTER)	6611 EBERLE	DR. APT 1	03 BALTI	MORE, MAR	YLAND 21215
re,	es 1 a of Hea of Hear r othe	20a. Method of Disposition 20b. Place	of Disposition (Name of ary, crematory or other place		Date 20	c. Location - City or 1	Town, State
Ë	Pages nant of I int: If its ury or o		LAWN CEMETERY				, MARYLAND
Baltimore	permit. Page Department of Important: If eny Injury or once.	21. Signature of Funeral Services Lice JONATHAN D. HI	NES Name and Address				
1		23a. Part1. Fater the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying	, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
1	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	- in tarct	- Den	rente	è l	year
	Je Je	Due to (or es a	consequence of):				years
	cate be axec ted physician and s the bunal-transit	Sequentially list conditions, if env. leading to immediate	a consequence of):	dent Di	1.10	1001	0
8760,	sician buria	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a condition of the condition of	consequence, of):	den Vil	quetes 6	Melkery	years
687	ficate be physicials the bur edical	resulting in death) Last	consequence or).				U
Box	laath cartific attending pl d for usa as t	d					
	at tha daath cartific by the attending p atached for usa as Physician/Me	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I.	23b. Did tobe	acco use contribute	to the cause of death?
P.0	that tha dailed by the a datached the physic	Der phoral voscilon di	Bense, Co	ronny	1 ☐ Yes	2 No 3□P	robably 4 Unknown
Vital Records,	been sign should be	Artery disease, Sei	rure disa	order,	24a. Was an performe	ed?	Were autopsy findings available prior to completion of cause of death?
Re	a has aga 2	recovered using t	ract int	ecturi	1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No
ita	certificata ractor, pag	25. Was case referred to medical		26. Place of Death	(Check only one))	
of V	Physician: r this certific and director,		Outpatient 3 DOA Othe	4 Nursing Hom		ce 6 □Other (Spe	cify)
o u	ng Pt fter th uneral	1 Natural 5 Pending (Month, Day Year)	. Time of 28c. Injury Work	rat 20 √? Yes 2 ∐ No	8d. Describe how	rinjury occurred	
Division	or Attending after death. Director: After din by the fune ertification	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, building, etc. (Specify)			8f. Location (Stre City or Town,	eet and Number or Ro State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificata ha completaly filled in by the funeral director, paga Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled and manner stated. 2 Indical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time and/or investigation, in my of	ne, date and place, as pinion, death occurre	nd due to the cau d et the time, dat	use(s) and manner as se and place, and due	s steted. e to the cause(s)
	ithin 2 ithin 2 or the I	29b. Signature and title of certifier	29c. License	number	290	d. Date signed (Mont	th, Day, Year)
	F.35.8	Whathan lile	GA an	5205	1	TugusT1	9,2005
	7	30. Name and address of person who completed cause of deat them 236	(Type, Print) Char	les St. E	alto 1	nd 2,2	2,6
7	State	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	Sparte				
	Registrar	ALIG 2 2 2000					

			State of Maryland / Department of Health and M	Mental Hygien	e 2005 of the		
			1- State Registrar Certificate of Death	Reg. M			
11	Physicia	_	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	ay Year 3. Time of Death		
	/Medic	al .	Charles Glock	Hugust	20 2005 1:50 AM		
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death August Augus	9 "	D LL E		
	Franci		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign		
	Funeral Director		214-20-10195 19 M 20 F 79 Yrs. Months Days Hours Min.	(Month, Day, Yea			
	ъ.		Usual Residence of Decedent				
	arylar show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 No		
	he M	Director	MD BALT MORE TOWSON 10e. Street and Number 10f. Zip Code	100.0	Citizen of What Country?		
	with is or		01001	109.	115 A		
	Jeath	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,		
9	or Iter	Fur	1 Never Married 2 Married 1 MYes 2 No	Rican, etc.)	Black, White, etc.		
5-0036	within 72 hours after death with the Maryland ene. than "naturel", or llems 23a or 28a-f show the Medical Extrib artriast be mailted at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: White.		
	natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business/Industry		
121	within ane. than	dw	Elementary/Secondary (0-12) College (1-4or 5+)	H	across Salt Ca		
d 21	filed Hygie other ent, II		17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Maide	en Sumame		
an	ould be filed with Mental Hygiene. arked other that atic event, Inc.	To Be	John Glock, Mari	e Luca	ssen.		
Maryland	is being	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rule)				
Σ	1 and 2 Health a em 27 Is		Lillian P. Glock 1220 Ridervalekd.	TOWSON	MD 21204		
ore	of He		1 Burial 2 Dicremation 3 Bernoval from State	1	Location - City or Town, State		
Ë	Pages tment of I tant: If its jury or o		'4 Donation 5 Other (Specify) FUNCEFACTION FOR	4-05 F	REST HILL, MO		
Baltimore	pernit. Pages Department of Important: If i any injury or ance				TIMONIUM MD 2109		
	402.40				EAC+ CROMATION CONTE		
J.			23a. Pdn1. Enter the disedse, or comblications that cau led the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final	- W1-1	Approximate Interval Between Onset and Death		
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death) a	HIZh	eimers		
	Examiner				9 months		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
	ate be executed hysician and the burial-transit	Examiner	that initiated events c.				
30,	be exe ician a burial-	Ě	resulting in death) Last Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d				
9 X	death certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery		
Вох	death atter	ciar	in the past 12 months? 1 Vec. 2 No. 4 Pregnant at time of death 5 Other (specify)		Month Day Year		
0.	that the de ed by the detached	hys	9 □ Unknown				
S, P	uires tha signed I d be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?		
ord	w require been si should l	ted		1 Tes	2 No 3 Probably 4 Unknown		
Records,	law r las be	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
E B	: The cate h	Cou		performed?			
of Vital	Physicien: The law this certificate has b ral director, page 2 s	Be	examiner?	th (Check only one)	- F70		
of	Phys rthis ral di	1; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in			
on	nding th. : Afte	tlor	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
Division	Atter	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street : City or Town, Sta	and Number or Rural Route Number,		
	rs afte	Cert	Duranty, co. (openly)				
	Hospi 4 hour uner	ical	29a. Certifier (Check only (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur				
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)		
	J. W. D. O.		D24149	233.2	123/05		
	1 40		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	1-0100		
	Dod		Donthis Snow MD 10 N. Greene S	+ Bal-	to mD 21201		
	Sta		31. Date filed (Month, Pay, Year) AUG 2, 3, 2005)			
Registrar ROG 2 3 2000							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST **Physician** 2005 12:15 John Ginn Henry /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18, 1918 9. Birthplace (State or Foreign Country) Minnesota 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F 87 468-12-8555 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be nutitied at 1 ☐ Yes 2 ☐ No Baltimore Directo N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5712 Willowton Avenue 21239 Items 23a United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or Items 23.
ury or other treumetic event, the Medical Examinat must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 Divorced WWII Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. 12 Computer Analyst Administration 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine Anastasia William Ginn David ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5712 Willowton Avenue Baltimore, MD Mr. David J. Ginn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny injury or once. Dulaney Valley Mem. Aug. 25,2005 Timonium, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC SMALL CELL CARCINOMA OF THE LUNG WEEKS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nown ACUTE UPPER GASTROINTESTINAL BLEEDING 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No has page 2 2X No certificate 1 Yes Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide 24 hours a 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of contifie 21,2005 D17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.0 ABDALLAH J. HELOU, M. D. 7601 OSLER DRIVE, TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 3 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		artment of H			iene g. k 2 0 0 5	27523	
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	h Day Yee	3. Time of Death	
	/Medic	al	LILLIAN 4a. Fecility Name (If not institution, give	E street and number		GONO 4b. City, Town, or	NSKY		20 2005 4c. County of De	5:00 A M	
	Examin	er	MILFORD MANOR NU			BALTIM			BALTIMORE		
	Funeral		5. Social Security Number 6. S	THE OWNER		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	irthplace (State or Foreign Country)	
	Director		215-10-3091 Usuel Residence of Decedent	97	Yrs.			01/27/1	908	MD	
	yland		10a. State 10b. County		Town or Lo					10d. Inside City Limits	
	Be-f s	ctor		TIMORE E	BALTIM					1 Tyes 2 No	
	with the a or 2	Funeral Director	10e. Street and Number	T DOAD		10f. Zip Code		10	Og. Citizen of What	Country?	
	Jeath Tie 23	erai	8531 MEADOWSWEE	12. Was Decedent Ever in U.S	i. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	U.S.A.	nerican Indian,	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "netural, or Itame 23a or 28e-f show or other treumatic event, the Medical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:			n, Mexican, Puert Specify:	o Rican, etc.)	Black, Wi	WHITE	
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ylaı	2 should be and Mental is marked (eumatic ev	To	NATHAN		I PMAN		DORA			CAPLAN	
Mar	nd 2 sh lth and 27 is m r treum		19a. Informant's Name/Relationship (City or Town, State		
ē,	tem 2 tem 2 other		20a. Method of Disposition	000	ce of Dispo	sition (Name of		and the second second	IMORE, MD		
E O	Pages nent of I ant: if its ary or o		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Hemovai from State		natory or other place MEMORIAL		21/2005	RANDALLST	OWN, MD	
Baltimore, Maryland 21215-0036	permit. Pages Department of Importent: If i any Injury or once.		21. Signature of Funeral Service Licer	See See				L LEVINS	ON & BROS		
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	snee of):						
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8760,	cate be executed physician and the burial-transit	dicai Examiner	,	Due to (or as a conseque	anca or).						
687	tificate ng phys as the	edic	a.								
Вох	andir use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy	ictoric pregnancy			elivery	
	that the death ed by the atte detached for	/sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of dea 9 Unknown		Other (specify)			Month	Day Year	
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rds,	quires n sign uld be							1 ☐ Yes	s 2 No 3	Probably 4 Wknown	
of Vital Record	e law has b	Completed						24a. Was an autopsy perform	prior to death	autopsy findings available completion of cause of	
ita	icien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ath (Check only one	No 1 □ Ye	es 2 No	
of ∨	di S	To B	examiner? 1 Yes 2 No		R/Outpatien		4 Uniursing H	lome 5 Resider	nce 6 Other (Sp	pecify)	
on c	ing P	ion:	27. Manne of Death 1atural 5 Pending	(Month, Day Year)	28b. Time of Injury	Work	at ? ∕es 2 □ No	28d. Describe how	w injury occurred		
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ă	s after al Dire	Certification:	4 Homicide	building, etc. (Specify)				City or Town,	State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1	ysicien: To the best of my know niner: On the basis of examination and manner stated.	rledge, death on and/or inv	n occurred at the time vestigation, in my op	e, date and place iinion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and de	as stated. ue to the cause(s)	
)	To You	Z	29b. Signature and the of certifier			29c. License	number 00574	.6 5	d. Date signed (Moi	nth, Day, Year)	
	3		30. Name and address of person who	completed cause of death (Item :	23a) (Type, i	Print)	Reiste	rstown, M	D. 21134	9	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ITO A	1 2 -					
	Registr	ar	AUG 2 3	2005 Reserve	N. A.	THE WAY					

			State of Maryla	and / Department of Health and N Certificate of Death		ene . n2 0 0 5	27524
	Physici		Decedent's Name (First, Middle, Last) EVERTON GRIFFITH JR.		2. Date of Death Month	Day 2805	3. Time of Death 553 QM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Stal Pri France	rfy	4c. County of Death	
	Funeral Director		5. Social Security Number 120-26-4201 6. Sex 1	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 6-25-19		place (State or Foreign ntry) V YORK
	show		Usual Residence of Decedent	City, Town or Location			10d. Inside City Limits
	after death with the Maryla or items 23e or 28a-f shov	Director	MD. N/A	BALTIMORE			1 M Yes 2 No
	with th	Dire	10.00 TOUNT OF	10f. Zip Code 21217	10g	g. Citizen of What Cou USA	ntry?
)	death	nera	12. Was Decedent Ever in Armed Forces?		pecify Yes or No-	14. Race - Ameri Black, White,	
) 0036	filed within 72 hours after death with the Maryland Hyglene. uther than "neturel", or items 23e or 28e-f show uther than "neturel", or items 23e or 28e-f show sht, the Medical Evaninger must be inclifted at	by Funerai	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	o rican, sic.,		LACK
215-0	nin 72 ho In "netul Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking 16	6b. Kind of Business/Ir	dustry
212	filed with Hyglene other tha	Com	-124-	PROJECT MANAGER		UNISYS	
) (Be	17. Father's Name (First, Middle, Last) EVERTON GRIFFITH SR.		ne <i>(First, Middl</i> e, Ma. IE LOGAN	uden Sumame)	
Lex Maryla	should be and Mental Is marked c	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru		City or Town, State, Zi	o Code)
S, M.	2 = 2 -		ALVA GRIFFITH(WIFE)	1208 JOHN ST. BALTI			
			1 ☐ Burial 2 ☑ cremation 3 ☐ Removal from State	b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or T	
EV21	permit. Pages Department of Importent: If i eny injury or o			ETRO CREMATORY 8-20 HIBNER Name and Address of Facility PH		ALTIMORE, I	
) Ba	permit. Departr Importe eny inji		I Towath O. This	1721-27 N. MONROE			•
	Enysician /Medical		23a. Pant Enter the disease, or complications that caused the dishock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a constitution)	te mycoodial infarcti	or respiratory arrest	t,	Approximate Interval Between Onset and Death
8760,	Examiner physician and the burial-transit	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a constitution of the condition of the c	sequence of Chrilation			20 years
P.O. Box 68	aath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ Pregnant at time of 9 □ Unknown	Fetal death 3 □Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
	uires that the de signed by the Id be detached	by	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	The law requite has been bage 2 should	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
/ital	cien: ertifica actor, p	BeC	25. Was case referred to medical examiner?		ath (Check only one))	
on of V	di ng Physicien: The l h. After this certificate ha funeral director, page	ion: To	27. Mayher of De th 12. Natural 5 Pending (Month, Day Year	28b. Time of 28c. Injury at	Home 5 Residence 28d. Describe how	ce 6 □Other (Speci rinjury occurred	fy)
Divisio	or Attendia after death. Director: A in by the fu	Certification:	Accident investigation Accident investigation	At home, farm, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Co		knowledge, death occurred at the time, date and place nination and/or investigation, in my opinion, death occu			
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	1 ₀ 29d	d. Date signed (Month,	Day, Year)
	10		7.00	(ttern 23a) (Type, Print)	40-1	1/20-1/20	1/2.002
			Thomas Pozetsky, Mil		4200 Litt	HERVITH, 11	W. 21093
•.	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	H. Sporte			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician AU GUST 2005 20 Hagerty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL GLENBURNIE Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2/□ F Months Days Hours Yrs. 220-56-0184 12/23/1914 New Jersey Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a 23a or 28a-f ehow 1 ☐ Yes 2 No Funeral Director MD. <u>Anne Arundel</u> <u>Glen Burnie</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 USA 407 Luther Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ [X] No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Itema
other traumatic evant, Ite Medical Examiliar. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 <u>Household</u> 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 is markad o Ulman. Unknown Unknown Unk 19b. Mailing-Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 504 Kent Road, Glen Burnie, MD 21060 Scott Wharton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory 8/22/05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Stallings Funeral Home, PA <u>3111 Mountain Road, Pasadena, MD 21122</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GASTROINTESTINAL Immediate Cause (Final disease or condition resulting in death) Physician 2 DAYS /Medical GASTRO INTESTINAL ULLER **Examiner** ERFORATED week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending s after decail Director: Alte 2 No 1 🗀 Yes investigation 2 Accident within 24 hours after dea To the Funeral Directo 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 💽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) AUGUST 20, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 HOSPITAL M.SHIRAZI, M.D.

MD DRIVE.

31. Date filed (Month, Day, Year)

(Check only one)

32. Registrarie Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Time o Death 1. Decedent's Name (First, Middle, Last) Year 1105A M **Physician** Hughett 2005 08 Jimmy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore University Maryland ot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG 26 1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 M M 2 □ F 56 218-52-4147 MD Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or itams 23a or 28a-f show other traumatic event, the Medical Evant artifulative rights at 1∭Yes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1623 St. Paul Street 21202 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. Int: if item 27 is markad other than "naturel", or Ital n No 1 Y Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Prater Hughett Francis Louise Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2425 St. Paul Street, Baltimore, MD 21218 Joan Toler - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 8/20/2005 Baltimore, MD 21. Signature of Funeral Service Licens CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Physician Pancreatic /Medical bue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death cartificate be exacuted Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signad by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 si 2FTNC certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 🗌 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this c 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director; / 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD P17672 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baltimore MD 21201 South Pontanilla 22 Evonne 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Division of Vital

State Registrar

the th

Greenberg lasha 31. Date filed (Month, Day, Year) 32. Requirar's Signature

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

found at home

111 Penn Street, Baltimore, Maryland 21201

Year

unk

29d. Date signed (Month, Day, Year) August 20, 2005

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death	lental Hygier	2005 //5/8
	Physici /Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Augo8	Day / Sear 3. Time of Death 2 2005 9 2 9 M 4c. County of Death
	Funeral Director		University of MD Methical Center Bath move Co. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Ye.	9. Birthplace (State or Foreign Country)
	Maryland a-f ahow illed at	ctor	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2☐No
	a with th	al Dire	10e. Street and Number 10f. Zip Code 8902 Montpelier Drive 20708		Citizen of What Country? U.S.A.
36	d 2 should be filed within 72 hours after death with the Maryland In and Mental Hygiene. 7 is marked other than 'natural', or Items 23a or 28a-f ahow traumatic avent, tra Madical Extr. in at transitive ricilinal at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 70 Dates: 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 houlene ihan "natura	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 + 16a. Decedent's Usual Occupation (Give kind of work done during most of working in the properties of the prope	ing	Kind of Business/Industry Container Company
	be filed Ital Hygir Id other avent, I	ae	17. Father's Name (First, Middle, Last)	(First, Middle, Maid	
Maryland	2 should be and Mental is marked of sumatic ave	ဥ	Uriel Mac Ham Helen Cu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		ry or Town, State, Zip Code)
	근들어느			Laurel,	
altimore,	permit. Pages 1 and Department of Healt Important: If item 2: any injury or other t		1 □ Burial XIXCremation 3 □ Bernoval from State cemetery, crematory or other place)		. Location - City or Town, State denton, Maryland
Baltir			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral 313 Talbott Avenue	Home, P.A	•
W	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac candidate Cause (Final disease or condition)		Approximate Interval Between Onset and Death
8760,	/Medical Examiner physician and the purial-transit	Ilcal Examiner	resulting in death) Due to (or as a consequence of):		(day)
O. Box 68	ath certific ttending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
σ.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	23e. Did tobacc	co use contribute to the cause of death?
of Vital Records,		Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vit	Physician: this certific ral director,	To Be	examiner?		6 🗍 Other (Specify)
Division of	ding h. After fune	Certification; 7		28d. Describe how in	
Divis	- 0	ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a company of the company of	ed at the time, date	and place, and due to the cause(s)
	To t To t	Σ			Date signed (Month, Day, Year)
•	20)	30. Name and add ss of person who complete leaves of death (Item 23a) (Type, Print) Mary Jo Halm 22 S. Greene St	Ball	Aug 15, 2005 1 Max, MD 21201
16	Sta Regist		31. Date filed (Month, Day, Year) () AUG 2 3 2005 32. Registrar's Signature	, , , , ,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jack J. Huff, AUGUST 17,2005 9:000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 213**-**32**-**1698 Mary 1 and 70 September Director 1934 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other then "naturel", or Items 23a or 28a-f shov treumetic event, Ite Medical Examiner must be notified at N/A Mary land Baltimore 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Cîtîzen of What Country? 4814 Richard Avenue 21214 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Huff Mary Catherine Mullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Huff/Wife 4814 Richard Avenue Baltimore Maryland 21214 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit, Page Department of Important: If any injury or once. Parkwood Cemetery 8/22/05 Baltimore Maryland 21. Signature of Funeral Service License Christina L. Hilton 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore Maryland 21214 K. Helton hustiaa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANEMIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** GASTROINTESTINAL BLEEDING DAYS Sequentially list conditions, Due to for as a consumence of Examiner If any leading to immodition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-fransit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PROSTATE CARCINOMA 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an METASTATIC TO BONE 2 Yes Hospital or Attending Physicien: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 1 Xes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA fhis 27. Manner of Death 1 SNatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the I To the 29b. Signature and title of certifier 29c. License number .2005 D17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 0 M. D. 7601 32. Recorar's Signature ABDALLAH HELOU OSLER DRIVE TOWSON, MARYLAND 21204 J. 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

			For State	State of Maryland / D	epartment of Health and		211115 275311
			Registrar		Certificate of Death	Reg. I	3. Time of Death
	Physicia /Medic	an i	1. Decedent's Name (First, Middle, Last,	HIGHTER			Day 2005 12:07 PM
	Examin		4a. Facility Name (If not institution, give	street and number) of Baltmore	4b. City, Town, or Location of Dea	th	4c. County of Death
i es N N Nga	Funeral	50431	5. Social Security Number 6. Se	7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hr	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	33	rs.	Month, Day, Ye. 114 31, 19	
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దా దు Maryland	and and sm		19a. Informant's Name/Relationship (T.	ype, Print) 19b. (HUSBAND) 49	Mailing Address (Street and Number or I	Λ.	ty or Town, State, Zip Code) WRE, MD 21215
_	es 1 and 2 of Health of Item 27 or other tre		20a. Method of Disposition 1 Degrial 2 Cremation 3	20b. Place of	Disposition (Name of y, crematory or other place)	Date 200	. Location - City or Town, State
	permit. Pages Department of Importent: if it any njury or o		4 Donation 5 Other (Specify 21. Signature of Fuheral Service License	CARRI	SON FUREST 8.	23.05 OW	RESENEL FUNERAL HAM
Chert Baltin	Departing Permit		MACI-	, †	4905 YORK ROM	BAUTIM	ORE, MARYLAND 21212
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P.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 1 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	res that the signed by	by	Part II. Other significant conditions co	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
cord	aw requ s been 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al Re	The is	Com				performe 1 ☐ Yes 2	d? death? No 1 ☐ Yes 2 No
Vit	sicien certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Ou	Other	eath (Check only one)	e 6 ☐Other (Specify)
n of	ng Phy fter this ineral d	I	27. Manner of Death 1XNatural 5 Pending	28a. Date of Injury 28b. 1	Fime of 28c. Injury at Work?	28d. Describe how	
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 a	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 Yes 2 No	28f. Location (Stree City or Town, S	ot and Number or Rural Route Number, State)
ام	pitei or urs afte erei Dir	Cert			e, death occurred at the time, date and pla		
	he Hos in 24 ho he Funi pletely f	ledicai			d/or investigation, in my opinion, death or	curred at the time, date	and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Mac	29c. License number		Date signed (Month, Day, Year)
	(1/)		30. Name an address of person who	completed cause of death (Item 23a)	(Type, Print)	Ho	2005 La Homore
1)			elson MD	Sinai Hosp	ital of Bo	althrore
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 3	2005 Signature	Sinai Hosp		

		-	State of Maryland / Department of Health and Mental H	Hygiene Reg. 2 005 27531					
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Month A B CRF FIRRES HARRS 2. Date of Month	Death Day Year 3. Time of Death					
	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death AVERT MEMORIAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Whoths Days Hours Min. (Month)	4c. County of Death CALVERT Birth 9 Birthplace (State or Foreign					
	Director Mog		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Pay, Year) VIKGINIA 10d. Inside City Limits					
21215-0036	th the Mar or 28a-f st e rotified	Director	BATIMORE 106. Street and Number 107. Zip Code	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show deal Exact must be collified at	by Funeral I	11. Marital Status 12. Was Decedent Ever in U.S. Armod Forces? 1 vever Married 2 Married 1 very Married 2 Married 1 very Married 2 No	T No. 14. Race - American Indian, Black, White, etc. Specify: BUACK					
	I within liene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER	16b. Kind of Business/Industry STEEL					
yland	should be filed nd Mental Hygi marked other umatic event, I	To Be (18. Mother's Name (First, Middle, Last) AUBERT HARRIS SINGNOR	A GARREH					
Baltimore, Maryl	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic ance.		20a. Method of Disposition 1	DALTU, MD 21239 20c. Location - City or Town, State BALTIMORE, MARYLAND C. GREENE FUNCTION. MTO, MD 21212					
8760,	zate be executed / Medical Examiner transit the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator. Due to (or as a consequence of):	Interval Batwaen Onset and Death 5 minu tes.					
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p cage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year					
	quires that n signed b uld be deta			Did tobacco use contribute to the cause of death?					
of Vital Records,		Completed by							
ion of Vit	<u> </u> = ∞	atlon; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 F	nly one) Residence 6 □Other (Specify) ibe how injury occurred					
Division	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City of City	on (Street and Number or Rural Route Number, Town, State)					
	To the Hospitel within 24 hours. To the Funeral completely filled	edical		me, date and place, and due to the cause(s)					
)	Tot with	M	29b. Signature and title of certifier 29c. License number 29c. License number 29c. D 50653	29d. Date signed (Month, Day, Year) 8-11-2005					
7	111		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GXAN C-SU/5851 - Deale Munch for Rd Deale MD	20751					
	Sta Regist		3111- 9 9 700E V. I. // At						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ 0 0 5 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) CINC If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 13 6 Sex Birthplace (State or Foreign Country) Days 1 M 2 F Hours 20 2487 Conn. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Charles Hughesville 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7113 Langley Court 20637 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2√ No If Yes, Give 23 Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify.African 1 ☐ Yas 2 ☐ No Specify: 3HWidowed 4 □ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harrington Edith Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Sullivan (Son) 7113 Langley Court Hughesville, Maryland 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2)☐(Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 22 Lee Crematory Clinton, Maryland rematory 2005 Clinton, M 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Fufferal Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6633 Old Alexandria Ferry Road Clinton, MD2075 Immediate Cause (Final disease or condition resulting in death) ANTERIOSCLENOTIC CAMSIONARGULAR DIJUE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Drabetes 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Cenebral Thrombosis 1 Yes 2 100 11 IYAS 21 NO 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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10a. State

Funeral

Director

important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ites

Baltimore, Maryland 21215-0020

the Maryland

death with

Examiner Physician/Medical Completed by Be

attending physician end for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed signed by the a I Director: After the in by the funeral efter death

Division of Vital Records, P.O. Box 68760,

Ity nentension 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide To the Hospital
within 24 hours of
To the Funeral Completely filled Hospital 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of Injury

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 2 3 2005

4203 Overson Rd Flyatta: 16 Mb 20181 32. Registrar's Signature

State

Registrar

			1 - State of N	/laryland / [rtment of H			iene eg. N2 0 0 5	27533	
			Decedent's Name (First, Middle, Last)					2. Date of Deat	th	3. Time of Death	
	Physicia /Medic	al	Kleber E. Hill					August	21, 2005	11:50 A M	
1	Examin		4a. Facility Name (If not institution, give street and number	or)		4b. City, Town, or	Location of Death		4c. County of Dea	th	
	- N		Franklin Square Hospital			Rosed			Baltim		
	Funeral Director	W.	5. Social Security Number 6. Sex 7. A	Age (In yrs. last bir 79	thday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 8, 19	Year) Co	thplace (State or Foreign ountry) th Carolina	
ш			Usual Residence of Decedent					100.071.	720 INOI		
	ylan		10a. State 10b. County	10c. City, Tow	n or Lo	cation				10d. Inside City Limits	
	a-f s	ctor	Maryland Baltimore	E	sse	X				1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zip Code	_	1	_	. Citizen of What Country?	
	ath w	rail	305 Locust Avenue			2122			USA		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked othar than "natural", or Itams 23s or 28a-1 show othar traumatic avant, the Medical Exural sectional terminists at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Was Deceder Armed Force 1 ☑ Yes 2 ☐ If Yes, Give Year or Date:	s? ⊒ No	11	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify:		
0	hour tural	ed b	15. Decedent's Education		. Deced	ent's Usual Occupa	ition	16b. Kind of		/Industry	
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212	d with giene ir tha	mo	Elementary/Secondary (0-12) College (1-40	St	atio	onary Eng	ineer		Aerospac	e	
pu	e file ai Hyg i otha vant,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Sumame)		
<u>ylaı</u>	should be filed withir and Mental Hygiene. s marked othar than umatic avant, the Ma	卢	Kleber L. Hill				Annie				
lar	2 sho and is ma		19a. Informant's Name/Relationship (Type, Print)						r, City or Town, State,	Zip Code)	
6	1 and 2 Health Iam 27 i		Rosella C. Hill (Wife) 20a. Method of Disposition			LOCUST AV sition (Name of	Committee and the Committee of the Commi		Md. 21221 20c. Location - City or	Town State	
Baltimore, Maryland 21215-0036	9 = 5 0 = 5		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Sta '4 ☐ Donation 5 ☐ Other (Specify)	te cemete	ry, cren	natory or other place eterans C	9) 0/24		Garrison F		
Balt	permit. Pa Departmen Important: any injury once.		21. Signature of Juneral Service Licensee John W. Burkhus	ke	l B	Name and Address ruzdzinsk 407 Old F	i Funera	l Home P venue Es	.A. sex, Md. 2	1221	
П		ý	23a. Part 1. Enter the disease, or complications that caus spock, or heart failure. List only one cause on each	n line.	not ente	er the mode of dying	g, such as cardiac	or respiratory arr		Approximate Interval Between	
	Pnysician	\$ 17	Immediate Cause (Final disease or condition	nroua.	ay	Arter	Disp	450		Onset and Death	
	/Medical Examiner		resulting in death) Due to (or	as a consequence	on:	/					
	LXammer	<u>.</u>	Sequentially list conditions, b. Due to (or.	as a consequence	of).						
	bed sit	nine	if any, leading to immediate Cause (Disease or injury	017.							
	sician and burial-transit	Examine	that initiated events c. Due to (or resulting in death) Last	of):							
8760,	cate be executed physician and the burial-transit	dicai E	d								
9	tificate ng phys as the	ledi	le sevus								
Вох	death certifi e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcor	ne of pregnancy 2 - Fetal death	1 3□	Ectopic pregnancy			23d. Date of de	olivery Day Year	
Ö.	the atte	hysician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	t at time of death	5 🗆	Other (specify)				20,	
٣.	es that the digned by the be detached	۵.	Part II. Other significant conditions contributing to death	h but not resulting i	in the ur	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute I	o the cause of death?	
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Records	> 4	ompleted		- 07				24a. Was a		utopsy findings available	
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Vital	ician: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of Dea	th (Check only on		2010	
<u> </u>	8 s p	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa	atient 2 ER/O	utpatien	t 307 DOA Othe	ar: 4 Nursing H	ome 5 🗆 Reside	ence 6 Other (Spe	ecify)	
υof			27. Manner of Death 1 XNatural 5 Pending 28a. Date of I		Time of	28c. Injun Work	at c?	28d. Describe ho	ow injury occurred		
Siol	Attending ir death. ector: Afte by the fune	catic	2 Accident investigation			M 1 🗀 '	Yes 2□No				
Division	l or Attencatter death Director:	Certification;	determined 288. Flace of	Injury - At home, fa etc. (Specify)	arm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	Rural Route Number,	
	urs a		CO. Conffice AV Conffice Physician Table				a data and place	and due to the co	C 2-2-		
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	To the Hospitel or At within 24 hours after or To the Funaral Direct completely filled in by	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Mon	th, Day, Year)	
1	F > F 0		Dr. the the	10 1.	۸,	Dos	3474	Go	8/22/0	<u>-</u>	
	1	L	30. Name and address of person who completed cause of	of death (Item 23a)	(Турв,	Print)	- L T	-	- 4	11	
	10		30. Name and address of person who completed cause of Author Harrely 31. Date filed (Month, Day, Year) AUG 2 3 2005	2112	Di	undallt	AVE	Duna	lalle MO	21227	
	Sta	100	31. Date filed (Month, Day, Year) 32. Regi	istrar's Signature	0046	es			-	3	
	Regist	rar	AUG 2 3 2005	0 23 19	100	P4.					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. () 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AV GUST R. Gordon Hoddinott 2005 00:26A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Catonsville Catonsville Balitmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1√ M 2□F Months 218-09-9999 86 Director 10-10-1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 Is marked other then "naturel", or Items 23s or 28e-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23s or 28e-f show ther must be notified at MD Baltimore Halethorpe 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 Winans Ave 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑X/es 2 □ No If Yes, Give 42-45 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status treumetic event, the Madical Exeminer Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Leyburn Hoddinott Emily Louise Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Hoddinott/ Wife 1811 Winans Ave. Halethorpe MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent; If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cemetery 08-18-05 Baltimore, MD * 4 □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility Surrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 21. Signature of Funeral Service Acensee 23a. Part Enter the disease, or confrications that cause of he death. Dunot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MUSUMONIA. Sequentially list conditions, if any, leading to immediate Due th (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2/ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 🔲 Yes 2 🗌 No Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29d. Date signed (Month, Day, Year 29b. Signature and title of pertifier 29c. License number 8005 August ad cause of death (bem 23a) (Type, Print) 50178 303. RANDALLSTOWN MEDICAL CENTER Name and address of person AVVERAHALLI OLDCOURT ROAD 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 00 Ru Charles Dale Hinkle 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Healthcare Baltimore Kanes if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 216-70-3725 9. Birthplace (State or Foreign 6. Sex IXOXM 2□ F Virginia Usual Residence of Decedent 10b. County Baltimore 10c. City, Town or Location Lansdowne 10a. State 10d. Inside City Limits MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 447 Caledonia Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 ☐No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Millen Evelyn Woodson Charles Albert Hinkle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 447 Caledonia Ave. Lansdowne, MD 21227 19a. Informant's Name/Relationship (Type, Print) Connie Hinkle/ Wife 20b. Place of Disposition (Name of cometery, crematory or other place) Meadowridge Memorial 08-20-2005 20a. Method of Disposition 20c. Location - City or Town, State P☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Selvice Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Panereati Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ♣ No 2DKNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Injury 5 □ Pendina 1 □ Yes 2 □ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physicien: The law requires that the death certificate be executed burial-transit physicien and Division of Vital Records, P.O. Box 68760. funeral director, page 2 should be peeu this certificate After To the many after death.
within 24 hours after death.
To the Funeral Director: Aft Hospitel å

Physician

/Medical

Examiner

Funeral

Director

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the Medical Examiner must be notified at

permit. Pages 1 and 2 should be tiled within 72 hours after death w. Depertment of Health and Mental Hygiene important: If item 27 is marked other then "natural", or Iteme 23s to enty hijury or other fraumatic event, the Medical Examinar manager.

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Examiner

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and attle of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month Day, Year) 14 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Agnes Hospital 900 Caton Avenue Baltimore MD 32. Resistrar's Signature

ORIGINAL

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0185

29d. Date signed (Month, Day, Year)

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	u .		Dr. Yolanda Aja	1a, 9000 Fr	anklin	Squar	e Driv	e Balti	more, N	11) 21237
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Baltimore,	ages Int of H		1 🗆 Burial 2 💢 Crem			State C6	emetery, cre	natory or o	ther place	1					
İţi	permit, Pages Department of Inportant: If Ite any injury or of		* 4 ☐ Donation 5 ☐ Oti 21. Signature of Funeral Se			Gre	en Mo					0-05	Baltimo	re, I	Maryland
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E R	Th ate pag	Соп			· • •							perfo 1 ☐ Yes		death? 1 🗌 Yes	2 XNo
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ion	F C 등 및	atlo	2 Accident	Pending nvestigat	ion	iii, Day 16ai)	Injury	М		r res 2□l	No				
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	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying I dical Ex	Physicien: To the aminer: On the b and man	best of my know asis of examinat ner stated.	wledge, deat ion and/or in	h occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, th occurr	and due to the ed at the time,	cause(s) and ma date and place,	anner as s and due to	tated. o the cause(s)
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	0/		30. Name and address of	erson wh	e N. K	se of death (Item	23a) (Type,	Print)	65	-65	N.C	Lorde S	+ 416	15 m	05
Ŷ.	Sta		31. Date filed (Month, Day,	Year)	32. F	egistrar's Signat	ture								
	Regist	-3	AHC o	200	5 BROSLA	11	home	6							
DΗ	MH 17 Rev 1/2	.001	HOU & C		J. A. CHELLA	and prof	ORIGIN	AL							

AEM # 05-05641 Harry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

У	Johnson	1]	For	State of Maryland	d / Depa	rtment of h	lealth and l	Mental Hy	/giene	
			1 - State Registrar		Cer	tificate of	Death		Reg. N. 0 0 5	27539
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)	IN HA	SON		2. Date of D	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	e street and number)	UAN		or Location of Death	August	4c. County of De	3:32p M
	Examin	er	3032 Ascension S				ore City	ı	N/A	atn
	Funeral		Social Security Number 6. S	Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi		rthplace (State or Foreign Country)
	Director		216-86-0007	M 2□F 34	Yrs.	Months Days	Hours Min.	FEB. 1		TRYLAND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
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	with the Maryland a or 28a-f ehow be notified at	irec	10e. Street and Number		·	10f. Zip Code	<u> </u>	~ 01	10g. Citizen of What C	Country?
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Directo	3032 A5	CENSION S	TREET		2123	25	45	A.
		unei	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	o- 14. Race - Am Black, Wh	
30	hours after tural', or Ite	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 2 🗷 No	Specify:			LACK
2-0036	2 hou	ted t	15. Decedent's Ed	ducation	16a. Deced	ent's Usual Occup	pation		16b. Kind of Busines	
בו	within 72 ene. than nai	Completed	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give I life. D	and of work done O NOT use retired	during most of wor d)	king		
7	ygiene yer thu	Con	12+AGRADE		BA.	ILBON,	D5MA	N.	INYOUTA	BAILBOND
	be file d oth	Be	17. Father's Name (First, Middle, Last)		/	-TX		,	a, Maiden Sumame)	- 1
ž	hould d Mer narke	၉	19a. Informant's Name/Relationship (JOHNS		OR.	AMA		Scu	
<u>8</u>	th an th an		Amanina Mangarielanising	DON (MATHER)	30. Mailing		ENSION	1	BALTO, M	
ē,	f Hea f Hea item		20a. Method of Disposition		ace of Dispos	ition (Name of atory or other place		Date	20c. Location - City o	0, 2/225 r Town, State
Ē	Page ient o nt: If		1. Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	JHemovai from State		/ `	TERY 08-	27-15	LANSDOW	JE MA
ā	rmit. poartm porta y inju		21. Signature of Funeral Service Licer		22.	Name and Addre	ss of Facility	MILITRE	FUNERAL	HOME
מ	89 2 2 3		Detuch.	N. William	0 3	140 N	FULTON	JAVE.	BALTO .	40.21217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death, one cause on each line.	Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Multiple &	unsha	T wan	als			Onset and Death
	/Medical Examiner		Tesuming in death)	Due to (or as a conseque	ence of):					
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õ X	death certificate attending phys	Physician/Med	IF FEMALE:	230 If was outcome of course						
X D	death o	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3□	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	olivery Day Year
j		ysic	1 Yes 2 No 9 Unknown	9□ Unknown	aur 5	Other (specify)				
7	law requires that the death as been signed by the atter 2 should be detached for u	by P	Part II. Other significant conditions of	ontributing to death but not result	ting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
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ecords,	lawre as bec 2 sho	Completed						24a. Was	an 24b. Were a	utopsy findings available
Ľ	Physician: The lar this certificate has al director, page 2	Com						perfo	psy ormed? 2 No	completion of cause of
VIII	iclan: sertific actor,	Be	25. Was case referred to medical examiner?	14			26. Place of Dea	th (Check only	one)	
5	Phys this o	P.	1 Yes 2 No 27. Manner of Death		R/Outpatient 28b. Time of		4 Nursing n		dence Other (Spe	At Scene
0	ding th. After	tion	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	2:521	28c. Injun Worl	k?' Yes 2 No		how injury occurred et was s	637
DIVISION	Attending Physiclan: r death. ector: After this certification by the funeral director.	ertification;	3 ☐ Suicide 6 ☐ Could not be	e 28e. Place of Injury - At hom				28f. Location /	Street and Number or B	
5	s afte	Cert	4 Aomicide determined	building, etc. (Specify)	heet		_	City or To	wn, State) ch Ascension	
	To the Hospitel or Attending Physician: The lawinin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of my know niner: On the basis of examination	ledge, death	occurred at the tin	ne date and place	and due to the	cause(s) and manner a	e stated
	the hin 24 the F	Medi	51.07	and manner stated.				rod at the time,		
	5. ¥ c o	-	29b. Signature and title of certifier	to al man		29c. Licenso	e number		29d. Date signed (Mon.	
	p A		30. Name and address of person who	completed course of death (first	22a\ /T C	OCME			August 21,2	.003
,	9		Tasha Zaveen			-	treet Ra	ltimoro	, Maryland	21 201
	Sta	te	31. Date filed (Month, Day, Year)	32. Ragistrar's Signatu	re		orcer, Da	TUNTE	, imprain	<u> </u>
	Registra	ar	AUG 2 3 2	005 Region 1	4. So	ade				

			1 - For State Registrar	State o	f Maryland /	Departme Certifica			ind Me		ene 0 0	5	27540
			Decedent's Name (First, Middent)	dle, Last)					2	. Date of Death			3. Time of Death
	Physici /Medic		BET	TY M.	JUBI	3				Month AUGUST	19 20	Year 05	1:20 A ^M
	Examin		4a. Facility Name (If not institution					Location of	f Death		4c. County o		
			GREATER BALT 5. Social Security Number	IMORE MEDI	CAL CENTE 7. Age (In yrs. last t		WSON or 1 Year	If Under 2	24 Hrs I o	. Date of Birth	BALTI		
	Funeral Director		216-20-9690	1□ M 2□F	79	Yrs. Months		Hours	Min.	(Month, Day,	rear)	MD	olace (State or Foreign ntry)
	ט		Usual Residence of Decedent							anc m	1520		
	arylar show	-	10a. State 10b. Count	•		wn or Location						1	10d. Inside City Limits
	28a-1	ecto	MD Balti 10e. Street and Number	more	T	imonium	p Code			10	g. Citizen of W		1 Tyes 2 No
	with with	ο	2 Glenamoy C	t. Unit 30	2		21093	}		10	g. Citizen or wi		nu y r
	death	Funeral Director	11. Marital Status		edent Ever in U.S.				gin? (Specif	fy Yes or No- can, etc.)	14. Race	- Americ	can Indian,
9	after or Ite	/Fu	1 Never Married 2 Ma	rried 1 ☐ Yes	2 X No	1 ☐ Yes		n, mexican, Specify:	, Puerto Aio	can, etc.)	Specify:	, White,	etc. vhite
21215-0036	hours tural',	Completed by	3 Widowed 4 Divorce	d Year or D	ates:								
5.	n "nai	plete	(Specify only high	nt's Education est grade completed)		a. Decedent's Us (Give kind of w life. DO NOT	ork done d use retired	during most)	of working	1 "	6b. Kind of Bus	iness/in	dustry
212	d with giene	E O	Elementary/Secondary (0-12)	College (Teletype	Оре	rator			AAI		
2	be file tal Hy d oth	Be	17. Father's Name (First, Middle	, Last)				18. Mother	r's Name <i>(F</i>	First, Middle, M.	aiden Sumame)	
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exaginational be notified at	မ	Edgar L. Joy			05-14-15-14-1	(2)			ne E. M			
<u>B</u> a	d 2 sh th and t7 is n traun		19a. Informant's Name/Relation Ralph K. Rot			9b. Mailing Addres 7508 Eas							Code)
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. Place	of Disposition (Natery, crematory or	me of		Date		Oc. Location - C		own, State
E	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ②Cremation 1 ☐ Donation 5 ☐ Other (Sidle	Comfort			/ 8/2	3/05 A	lexand	ria.	VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinational Le notified at ODGe.		21. Signature of Funeral 5	jiovinee)		22. Name a	nd Addres	s of Facility	y				
Michaer J. Fragie 10 W. Padonia Rd., Timonium, MD										Valle D	ings Inc.		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of st only one cause on a	aused the death. De each line.					-		- 15	Approximate Interval Between Onset and Death
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38760,	physics the b	dical		d									
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	that the death ned by the atter detached for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregr	pirth 2 Fetal dea nant at time of death						Mont	h	Day Year
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	uires tha n signed l		Part II. Other significant condit			in the underlying	cause give	en in Part I.		23e. Did toba			he cause of death?
Ö	w requi	eted	nepperle	alesters					_				
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Vital		0	25. Was case referred to medic	al				26 Place	of Death (C	1 Yes 2		Yes	2 No
ί	S S	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2 ER/C	Outpatient 3 D	OA Othe			5 Residen		(Specif	y)
n of			27. Man of Death 1 Natural 5 Pend	ing 28a. Date	of Injury th, Day Year)	Time of Injury	28c. Injury Work	at	280	d. Describe how			
sio	Attending r death. ector: After by the fune	cati		tigation		M		res 2□N		1 104			15
Division	l or Al after of Direct	Certification:	4 Homicide deter	min 286. Place build	of Injury - At home, ing, etc. (Specify)	tarm, street, facto	гу, опісе		201	City or Town,	State)	or Hura	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certify	ing Physician: To the	best of my knowled	ge, death occurred	at the tim	ie, date and	i place, and	due to the cau	se(s) and man	ner as si	tated.
	he Ho in 24 I he Fu pletely	Medical	(Check only 2 Medica	I Examiner: On the band man	asis of examination a ner stated.	and/or investigatio	n, in my op	oinion, deatl	h occurred	at the time, dat	e and place, an	d due to	the cause(s)
	To the within 2	Σ	29b. Signature and its of contiff	er	1)	29	c. License	number		290	1. Date signed	Month.	Day, Year)
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	Registr	rar	AUG 2 3 200	O Allaeva	10. 19								

			1 _ State	tate of Maryland	d / Depa		lealth ar		•	2761.1
			Registrar 1. Decedent's Name (First, Middle, Last)		061	incate of	Dealii	2. Date of De.		3. Time of Death
	Physici		Calvin Leslie	Jackson				Aug. 12	Day Year	9:25 PM
	/Medio		4a. Fecility Name (If not institution, give street			4b. City, Town, o	r Location of I		4c. County of Dee	
			Manor Care Ruxton			Tows	son		Balt	imore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bird (Month, De	9. Bin (y, Yeer) 9, 1920	hplace (State or Foreign ountry) MD
	Director		219-03-0214 Light Market State of December 1 Market	84	113.			Sept.	19, 1920	MD
	ylanc		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ba-f s	Director	MD Freder	ick	Thurmo	ont				1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	s 234	erai	67 Pleasant Acres	Dr . Was Decedent Ever in U.S	12 1		L788	2 (Specify Vec or No	USA - 14. Race - Ame	vican Indian
	iter d	Funerai		Armed Forces? IXIYes 2 □ No	13. 1	Yes, specify Cub	an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Black, Whit	
8	al', ol	by		If Yes, Give Year or Dates:	1	☐ Yes 2🌠 No	Specify:		Specify: W	hite
5	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Madical Examinatorium be notified at	Completed	15. Decedent's Education (Specify only highest grade co		(Give	lent's Usual Occup	during most o	f working	16b. Kind of Business	Industry
121	within one. than *	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)		Dhama	ceutics
2	Hygi Hygi ther nt, t		12 17. Father's Name (First, Middle, Last)	N/A	Pnarma	aceutical		Name (First, Middle,		ceutics
lan	should be filed within 72 hours after death with the Marylan and Mental Hygiene. I marked other than "naturel", or items 23a or 28a-1 show umatic event, it is Medical Exercities must be notified at	To Be	William Henry Jackso	n					abeth Kiese	1
Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic.	1	19a. Informant's Name/Relationship (Type,						er, City or Town, State, 2	
	Health Health tem 27 other t	1	Leslie A. Jackson/ 20a. Method of Disposition	20b. Pla	ice of Dispos	sition (Name of	T		mont, MD 2	
altimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	John John Irch Ce	s Luther emetery	ran Au	ig. 26,	Sweetair,	MD
Balti	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee	, one	22	Name and Addre	ss of Facility	272-77		
	00 E € Ø		23a. Part1. Enter the disease, or complication	J. Flagie					ney Valley m, MD 21	
			shock, or heart failure. List only one call	ause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	CERES	PRO (MSCU	LAK	1 HRO	11100315	yrs.
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	D #3	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque						
1	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):					
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0	uires that the de signed by the a td be detached f	Physician/Med	1 Ves 2 No	4□Pregnant at time of dea 9□Unknown	ath 5□	Other (specify)				July 15th
۹.	s that I	by Ph	Part II. Other significant conditions contribu	uting to death but not resul	ting in the un	iderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	w require: been sig should be							1 🗆 Y	es 2□No 3□Pr	obably 4 nknown
Records,	The law requires that the te has been signed by though 2 should be detached.	Completed						24a. Was autop	sy prior to d	topsy findings available completion of cause of
	(4)							perfor	med? death? 2 No 1 ☐ Yes	2 🗆 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ital:		Oth		Death (Check only of		
ō	Phy this ral d	—	1 Yes 2 No	8a. Date of Injury 2	R/Outpatient 28b. Time of	28c. Injun	y at		ence 6 Other (Spec	cify)
0	Attending Indeath.	atio	1 Datural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1	k? Yes 2 □ No			
Division		Certification:	3 Suicide 6 Could not be determined 2	8e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number or Au n, State)	ral Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier Certifying Physicia	n: To the best of my know	lodge death	accurred at the tip	no data and s	along and dup to the		
	ne Hospital n 24 hours a ne Funeral to bletely filled	Medical	(Check only 21 Medical Examiner:	On the basis of examination and manner stated.	on and/or inv	estigation, in my o	pinion, death	occurred at the time, o	date and place, and due	to the cause(s)
	To the l within 2. To the l complet	Σ	29b. Signature and title of certifier	11		29c. Licens	e number	2	29d. Date signed (Month	i, Day, Year)
	- 1/1		1/1/Con	adi m		W-	1284	9	0-13-	05
	271		30. Name and address of person who complete the filed (Month, Day, Year) AUG 2 3 2005	eled cause of death (Item :	23a) (Type, F	0 OSL	ER	Dr. To	WSON M	D 21204
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re Annell	19		- /-		
	Registr	ar	AUG 2 3 2005	Color D.	SATERIAL					

				1- For State of Maryland / Department of Health and M Certificate of Death	_	giene Reg. N2. 0 0 5	2751.2
				1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
_		 Physici /Medic 		Clement E. Jackson	Augus	t 19,2005	10:40am
		Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
	,	36		Joseph Richey Hospice Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	th Q Rint	hplace (State or Foreign
		Funeral Director		MANKNOUN 12 M 2 F 51 Yrs. Months Days Hours Min.	(Month, Da	y, Year) Co	MAryland
		pur 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	•		10d. Inside City Limits
		Marylan f show	ō	MD Baltimore Essex			1 ☐ Yes 2 ☑ No
\		h the Mirror	irect	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
(0)		23s o	by Funeral Director	913 Foxcroft Lane 21221		USA	
6		er dez Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes yeer Married 2 □ Married 1 □ Yes 2 □ YNo	pecify Yes or No- Pican, etc.)	- 14. Race - Ame Black, White	rican Indian, e, etc.
200	5-0036	ursaft al', or	by F	3 Widowed 4 Divorced Year or Dates:		SpecifyWhi	te
	5-0	Juithin 72 hours after death with the Maryle jiene. jiene. rrthan "natural", or Items 23s or 28a-1 shourthan "madical Examirer in uat be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) [Secondary (0.12) College (1.40 E.) [Secondary (0.12) College (1.40 E.) [Ife. DO NOT use retired)	king	16b. Kind of Business/	•
310	121	within ene. than '	dmo	Cal pelicer		HomeImpro	vement
の独	19	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or tems 23a or 28a-1 show event, if a Madical Examera number or matter profited at	Be Co			Maiden Sumame)	
	ylar	12 should be filed withir or and Mental Hygiene. I is marked other than raumetic event, It a M.	ToB	Homer Jackson Gertrud	de Earl	e	
S	Maryland	is 1 and 2 should of Health and Menitem 27 is marke other traumetic.	10.0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru. Kenny Jackson / brother 1410 Sussex Roa			. ,
27.0	<u>6</u>	Health Health tem 27 i	1	20a. Method of Disposition 20b. Place of Disposition (Name of	Date Dail	20c. Location - City or	
Apires	altimore,	Pages nent of I int: If it		1 Burial 2 Perenation 3 Removal from State 3 Other (Specify)	22/05	Baltimore	e MD
-	Balti	permit. Pages Deportment of H Important: If its any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	onnelly	 /FuneralHc	meofEssex
		2.0 = € a		1. /My Onnelly 300 Mace Ave Ba	altimor	ce MD 2122	21
_		all large		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respiratory ar	rest,	Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death) a. Media death Curacy Lung Pure to (or as a consequence of):			3 moreth
		Examiner		Sequentially list conditions b. Caresnon at the colon			5 1040
		be isi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury			3
~	,	execut n and al-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
0	8760	Attanding Physicien: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit		d			
5	9	artifica ling ph e as th	Med	IF FEMALE:			
Acks	Box	eath certific attending pl	by Physician/Medical	23b. Was decedent pregnant in the past 12 months?		23d. Date of deli Month	very Day Year
F	0	w requires that the d been signed by the should be detached	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
	s, P	ires tha signed I d be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
1	ord	requir een si nould	eted	Patmonary combati	1 🗆 Y	res 2□No 3□Pro	obably 4 ⊉Unknown
EMENT	Vital Records,	The law cate has b	Completed	An emi a	24a. Was autop		topsy findings available ompletion of cause of
5	tal	i cien: The lar certificate has rector, page 2	e Co	25. Was case referred to medical 26. Place of Deal	1 ☐ Yes	2 No 1 UYes	2 □ No
Vi	of Vi	Physicia this cer al direct	To Be	examiner?		dence 6 Other (Spec	ify) Has g. C
-		ing Pt	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Injury Work?	28d. Describe h	now injury occurred	
0	Division	Attand death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined.	28f. Location (S	Street and Number or Ru	ral Route Number
	Div	al or A	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow	n, State)	
		To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and date a	and due to the c	ause(s) and manner as date and place, and due	stated. to the cause(s)
		ro tha within To the	Mec	one) and manner stated. 29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Month	, Day, Year)
				Rolfe B. Finn. M.D. 20002175		8-19-05	
		27		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolfe B. FENM			
		Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		Registi	ar	31. Date filed (Month, Day, Year) AUG 2 3 2005 32. Registrar's Signature			

	1 - For State Registrer	State of Mary	land / Depa		ealth and	Mental Hygie	_	077710
Physician /Medical Examiner	Decedent's Name (First, Mi. Au Facility Name (If not institute)	ra		4b. City, Town, or		2. Date of Death Month	Day Year 5 2005	
Funeral Director	5. Social Security Number 123.42-5201	Marylan	yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	rince (gear) 9. Birth Con	nplace (State or Foreign intry) H Carolina
with the Maryland a or 28a-f show be notified at Director	Usual Residence of Decedent 10a. State 10b. Cou	nty 10	c. City, Town or Lo					10d. Inside City Limits 1. Yes 2 □ No
death	10e. Street and Number 1535 #318 11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hilf Yes, specify Cuba	spanic Origin? (§		J. Citizen of What Co	ncan Indian,
	1 Never Married 2 No Nover Married 2 No Nover Married 2 No No No No No No No No No No No No No	If Vac Giva	16a. Dece	1 Yes 2 No	Specify: ation furing most of wo	16	Specify: 5	PACK
	Elementary/Secondary (0-1)	le, Last)	1	DO NOT use retired 3 AB/e	D	me (First, Middle, Ma		(Ke)
Mary nd 2 shou sith and M 27 is mar r traumat	19a. Informant's Name/Relation TELIA 20a. Method of Disposition	JONES (DAUGHT	19b. Mailiner) 1535	#318 Un		****	Brunt NY	NY 10453
Baltimore, permit. Pages 1 a Department of Hez Important: If item any Injury or other pince.		n 3 Removal from State (Specify)	seorge U	natory or other place A S H IN 9 A 2. Name and Addres	s of Facility	3/2005 /		ew Jersey
Physician /Medical	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or complications that caused the ist only one cause on each line. a	esti			/4 m C 4		Approximate Interval Between Onset and Death
8760, cate be executed with social and the burial-transit and the burial-transit and dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	actions of):	molys	2			n Knows
Records, P.O. Box 68 The law requires that the death certificat te has been signed by the attending phy bage 2 should be detached for use as the completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
cords, P.		itions contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		cco use contribute to	
	CrCuth Ne				26. Place of De	24a. Was an autopsy performe 1 Yes 2 ath (Check only one)	prior to death?	topsy findings available ompletion of cause of
sion of tending Physeath. or: After this the funeral di	3 Suicide 6 □ Cou	Hospital: 1 Pinpatient 28a. Date of Injury (Month, Day Ye stigation Id not be mmined 28e. Place of Injury building, etc. (S	At home, farm, sti	f 28c, Injury Work M 1 🗆 \	at	28d. Describe how 28f. Location (Streichty or Town,	injury occurred et and Number or Ru	
DIVI. To the Hospital or At within 24 hours after dividing the Funaral Direct completely tilled in by Medical Certiff.	29a. Certifier 1 Certific (Check only one)	ying Physician: To the best of m al Examiner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tim vestigation, in my op	e, date and plac pinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
with voin To com	29b. Signature and title of cert	fier ALL ~, on who completed cause of death	(Item 23a) (Type.	29c. License	number 154	29d	I. Date signed (Month	, Day, Year)
State Registrar	31. Date filed (Month), Day, Ye	of Creongra	Ave Sin	3-4	1 2,1	res spri.	ng mO s	20902
DHMH 17 Rev 1/2001	AUG 2	3 2005 Stave	ORIGINA	\L				

Physician Register Certificate of Death Register Certificate of Death Register Certificate of Death Register Certificate of Death Register Certificate of Death Register Regis	1
Physician Agnes June Kessler	14
Agries Suffer Agries Suffer Agries Agries Suffer Agries A	_
Funeral Director Sultimore washington medical Center Glen Burne Funder 24 Hrs. S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) March 12, 1941 Maryland Usual Residence of Decedent	
Director 212-40-4211 1 M 2 DF 64 Yrs. Months Days Hours Min. (Months, Day, 79an) Warch 12, 1941 Maryland Usual Residence of Decedent	
	oreign
Maryland Anne Arundel Pasadena 1 Yes 106. Zip Code 109. Citizen of What Country?	Limits
10e. Street and Number 8378 Oak Drive 10f. Zip Code 10g. Citizen of What Country? 11g. Was Decedent Ever in U.S. Armed Forces? 11g. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Never Married 2 XMarried 1 Yes, Give Year or Dates: 11g. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 13g. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14g. Race - Armerican Indian, Black, White, etc. 15g. Decedent's Education 1 Ga. Decedent's Usual Occupation 1 Ga. Decedent's Usual Occupat	IX No
8378 Oak Drive 21122 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 14. Race - American Indian, Black, White, etc. 15. Decedent's Education 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 1	
3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. Do NOT use retired) Homemaker Household	
Homemaker 18. Mother's Name (First, Middle, Maiden Sumame)	
Edward C. Reck. Sr. June T. Winebrenner	
The property of the property o	
Donald L. Kessler, Sr spouse 8378 Oak Dr., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, crematory or other place) 20c. Location - City or Town, State	
1 ABurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Slen Haven Cemetery Aug 26 Glen Burnie, Mu	
20a. Method of Disposition XBurial 2 Cremation 3 Removal from State XBurial 2 Cremation 3 Removal from State XBurial 2 Cremation 3 Removal from State Yame of Disposition (Name of Veremetery, crematory or other place) Yame of Disposition (Name of Veremetery, crematory or other place) Yame of Disposition (Name of Veremetery, crematory or other place) Yame of Disposition (Name of Veremetery) Yame of Disposition (Name of Veremet	
23a. Part 1. Enter the disease or complications that caused the dectar Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Betwoen the Control of	
Physician Immediate Cause (Final disease or condition resulting in death) Medical Immediate Cause (Final disease or condition resulting in death)	
Examiner Control Washington During	
if any, Fator Lightlying Due to (or as a consequence of):	
Due to (or as a consequence of): Street Cause Chief Cause Chief Cause Chief Cause Chief Cause Chief Cause Cause Chief Cause Chief Cause Cause Chief Cause Cause Chief Cause Cause Chief Cause C	
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y C of the second seco	ath?
So Secre exterior sclering Dishele 10 Yes 20 No 3 Probably 4 Do	nknown
Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of):	railable use of
25. Was case referred to medical examiner? 1 Yes 25 Mo 25 Was case referred to medical examiner? 1 Yes 25 Mo 25 Was case referred to medical examiner? 1 Yes 25 Mo 25 Was case referred to medical examiner? 1 Yes 25 Mo 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner? 1 Yes 25 Was case referred to medical examiner?	
27. Manner of Death 1 Set Time of Injury 27. Manner of Death 1 Set Time of Injury 28a. Date of Injury 28b. Time of Injury 3 Superior of Death 1 Set Time of Injury 4 Month, Day Year) 28d. Describe how injury occurred	
27. Manner of Death 1 Senatural 5 Pending investigation 3 Solicide 4 Homicide	er,
C oc oc	
29a. Certifier 1 **\infty** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29a. Certifier (Check only one) 4 **\infty** A displayed by the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a. Certifier 20a. Certifie	
	-
D03607 8/19/05	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. CERINO 7600 03 LER DIR BALTO, HD.	
State Registrar AUG 2 3 2005 Anne and address of person who completed datase of death (liter) 23a (Type, Philit) M. CERLING 7600 C3 LETR D12. BALTO. HD. 31. Date filed (Month, Day, Year) 32. degistrar's Signature	

		1	For State Registrer		S	State of I	Maryla	nd / Depa <i>Cei</i>	artment rtificate			and Me	ental Hy	giene Reg. N	00	5	27545	
			1. Decedent's Nam	e (First, Middle,	Last)								2. Date of De			Vane	3. Time of Death	
	Physicia /Medic	al .	Florence						1		· · · · · · · · · · · · · · · · · · ·		August		<i>i</i> , 2	Year 005	7:30 F	М
	Examin	er '	4a. Facility Name (If not institution,	give stre	eet and numb	er)		4b. City,	Town, or	Location o	of Death			. County			
			1022 Bee					t - 4 t late d - 1	Rose If Under		If Under	24 Hrs	8. Date of Bir		ltim		ann /State or Fore	ian
П	Funeral Director		5. Social Security N 219–10–6		6. Sex 1 🗌 N	2 X F	Age (in yrs	i. last birthday) 79 Yrs.	Months	Days	Hours	Min.	Oct. 1	Year	925		ace (State or Fore try) vland	gn
			Usual Residence o	of Decedent			10-0									1	Od. Inside City Lim	its
	ahow		10a. State MD	Baltime	ore		10c. C	ity, Town or Lo Roseda								,	1 ☐ Yes 21 7 1	
	28a-f	5	10e. Street and Nu	L				100000	10f. Zip	Code				10g. Ci	itizen of W	/hat Coun	try?	_
	with 3a or	0	1022 Be		Δτια	nua			21	237				U.S.	Δ			
	ns 2:	era	11. Marital Status	echare		. Was Decede		U.S. 13.	Was Deced	dent of His	spanic Ori	gin? (Spe	cify Yes or No		14. Race	- Americ		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it itam 27 Ia marked other than "natural", or Itams 23a or 28a-f ahow or other traumatic avant, the Medical Evantuar must be notified at	by Funeral		ried 2 Marri	ed	Armed Force 1 Yes 2 If Yes, Give Year or Date	[XNo	1	If Yes, spec 1 ☐ Yes 2		Specify:	i, Pueno i	ncan, etc.)			k, White, Whit		
21215-0036	2 hou natura Icul E	ted		15. Decedent	's Educa	tion		16a. Dece	dent's Usua	al Occupa	ition urina mos	t of workir	na	16b. F	Kind of Bu	siness/Ind	dustry	
218	ithin 7 ne. han "r	Completed	Elementary/Sec		, grado t	College (1-4	lor 5+)		kind of wor DO NOT us emaker				3	ONUT	n Hom	<u> </u>		
	tygier tygier ther th		8th 17. Father's Name	/Eiret Middle	act)			попе	andver		18. Mothe	er's Name	(First, Middle					
and	d be fi	o Be	Stephen									lian		,		,		
Maryland	12 should be filed within? h and Mental Hygiene. 7 Is marked other than " traumatic avant, tha Me.	2	19a. Informant's N	Name/Relations	nip <i>(Type</i>	, Print)		19b. Mail	ing Address	(Street a	ınd Numbi	er or Rura	i Route Numb	ber, City	or Town,	State, Zip	Code)	
	and 2 saith a n 27 is ar tra	8 8	Florenc	e Dean/	Daug	hter			Beech		Aver		Roseda					
Baltimore,	ges 1 r of He If itan		20a. Method of Dis 1 TBurial 2	sposition Cremation	3 □Rer	noval from St	ate	Place of Disp cemetery, cre	matory or o	ther place			ate		_ocation -	•	wn, State	
ţ	permit. Pag Department Important: any injury once.	1	° 4 ☐Donation 21. Signature of F	5 Other (Sp			S	t. Star				8/20	/05 .ch/Ros		altim		l Home	
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		1	Da	7	L X		1	211 C	hesa	co A	venue	Rose	dale			237	
	Physician		23a. Part1. Enter shock, or he Immediate Cause disease or condit	art failure. List e (Final	complica only one	ations that cau cause on eac	used the de ch line.	ath. Do not er	ter the mod	de of dying	g, such as	cardiac o	r respiratory :	arrest,			Approximate Interval Between Onset and Death	
	/Medical		resulting in death		(a.	Due to (o	r as a cons	eq nce of):	1	-	1130	11/20				-	9 (0)12	
8	Examiner	<u>.</u>	Sequentially list of	conditions,	b.	Due to (o	r as a cons	equence of):	77.							-		
X.	ted nsit	Examiner	Sequentially list of any, leading to cause. Enter Unio Cause (Disease of that initiated even	immediate lot ying or injury	<	Due 10 (0	1 23 2 00110	04401100 017.										
60,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ai Exa	resulting in death) Last	c.	Due to (o	r as a cons	equence of):										
68760	physicate t	edicai			d.													
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decede	ent pregnant	23	c. If yes, outco			□Ectopic p	reanancy						te of delive		
	it the death by the atte tached for	Physician/M	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	No		4∏Pregna 9∏Unknov	nt at time o		Other (sp						Мо	ntn	Day Year	
P.0	that the ed by detac	/ Ph	Part II. Other sign		ons conti	ributing to dea	ath but not r	esulting in the	underlying o	cause give	en in Part	l.	23e. Did	tobacco	use cont	ribute to t	ne cause of death?	,
rds	v requires been sign should be	ed by											1.4	Yes	2 🗆 No	3 🗌 Prot	ably 4 Unkno	wn
eco	law renas bee	Completed											24a. Wa aut	s an opsy formed?		Were auto prior to co death?	psy findings availa mpletion of cause	.ble of
E	: The l cate ha	Con											1 Tes	34 N		Yes	28 No	
Vita	siclan: certific irector,	o Be	25. Was case ref examiner? 1 Tes 20		-	spital:	patient 2	☐ ER/Outpatio	ent 3 DC	Oth			me Check only		6 □Oth	er (Specil	v)	
ō	Attanding Physiclan: r death. setor: Atter this certified by the funeral director,	-	27. Manner of De	ath		28a. Date of		28b. Time		28c. Injun Wor			28d. Describe				,,	
ion	uttanding I death. ctor: After y the funer	atio	1 Natural 2 Accident		gation	(10701711	, Day 7 Our,	пцату	М		Yes 2□							
Division of Vital Records,	afte Dire	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ		28e. Place o buildin	of Injury - A g, etc. (Spe	t home, farm, s ecify)	treet, factor	ry, office			28f. Location City or T			er or Run	al Route Number,	
	To tha Hospital or within 24 hours afte To tha Funaral Dir. completely filled in 1	Medical C	29a. Certifier (Check only one)	Certifyin 2 Medical	ng Physi Examin	cian: To the ler: On the ba	sis of exam	knowledge, dea ination and/or	ath occurred investigation	at the tin	ne, date a pinion, de	nd place, ath occurr	and due to th red at the time	e cause(e, date a	(s) and ma nd place,	anner as s and due t	tated. o the cause(s)	
	o tha ithin 2 o tha omplei	Med	29b. Signature at	nd title of certifie)r	and marin			29	c. Licens	e number			29d. D	ate signe	d (Month,	Day, Year)	
	- 5 - 0)	Ger 9	-60	env	2			1	00	206	13	5	1/19	1/05		
	15		30. Name and ac	ddress of person	who con	npleted cause	of death (I	tem 23a) (Typo 7602	Br 16	414	RD	B	Ha	me,	me	21	236	
		ate	31. Date filed (M			32 Re	egistrar's Si	gnature										
	Regist	rar	ĺ	MG 2 3	2005	A Land and	PLACE E	D. Oct	BULL !									

		ļ	For State Registrer	State of Maryland / Dep	partment of Health and ertificate of Death	d Mental Hyg	•
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Sept. Aa. Facility Name (If not institution, give s	knaver		2. Date of Dea Month	th Day Year 3. Time of Death 19 2005 10:05 PM
	Examin Funeral	er	Riverview Care Cent 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda			4c. County of Death Baltimore 9. Birthplace (State or Foreign Country)
	Director		213 28 8593 1 Nusual Residence of Decedent 10a. State 10b. County	M 2□F 72 Yrs.		8. Date of Birth (Month, Day March 2!	Pennsylvania
	h the Mary r 28a-f aho	Funeral Director	Maryland Baltimore	e Esse	X 10f. Zip Code	1	1 ☐ Yes 2X No Og. Citizen of What Country?
	s 23a o	raiD	305 Capitol Court		21221		USA
036	within 72 hours atter death with the Maryland ana. than "natural", or Items 23a or 28a-f ahow fre M.cdical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2□No If Yes, Give Korean Year or Dates: Conflict	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu □ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	be filed within 72 hours after death with the Marylar Ital Hyglana. Id other than an atural; or Items 23a or 28a-f ahow avent, the Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) 16a. Dec (Giv life.	sedent's Usual Occupation we kind of work done during most of the DO NOT use retired) CCOUNTANT		16b. Kind of Business/Industry Finance
Maryland 2	should be filed withir ind Mental Hyglana. I marked other than umatic avent, Ibo M.	To Be C	17. Father's Name (First, Middle, Last) Frank Knauer			Name (First, Middle, Proeller	Maiden Sumame)
	nd 2 state at trau		19a. Informant's Name/Relationship (Type Dolores Knauer (With		iling Address (Street and Number or Capitol Ct. Balt		
Baitimore,	Page nent or int: If		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	rematory or other place)		20c. Location - City or Town, State Baltimore, Maryland
Bait	permit. Departm Importa any inju		21. Signatur of Funeral Service License	kowske	^{22. Name and Address of Facility} Bruzdzinski Funei 1407 Old Fastern	Avenue Es	sex, Md. 21221
	Pnysician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not e a cause on each line. Due to (or as a consequence of):	nter the mode of dying, such as card	liac or respiratory arr	est, Approximate Interval Between Onset and Death
/60,	ate be executed by sician and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discourage) that initiated events resulting in death) Last	Due to (or as a consequence of):			
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed b should be deta	ρχ	Part II. Other significant conditions con	inbuting to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 ⊟tonknown
of Vital Records,		Completed	1 by perteusin			24a. Was a autops perform	prior to completion of cause of death?
ion of Vita	Jing Pl	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other. 4 Nursing		ence 6 Other (Specify) ow injury occurred
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely (illed in by the t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)
	To tha Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier 1. Certifying Physical (Check only one) 2. Medical Exemination	icien: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death or	ace, and due to the cocurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier	Curron	29c. License number		9d. Date signed (Month, Day, Year)
	141		30. Name and address of person who con	npleted cause of death (Item 23a) (Type	e, Print)		5 2005
	Sta	te.	Michael Schwartz M 31. Date filed (Month, Day, Year)			21061	
	Registr		AUG 2 3 2005	32. Hegistrar's Signature	de la		

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 8 Year Physician 3:30 AM 2005 eR Ve /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BACTIMORE ROSEDALE FRANKLIN SQUARE HOSPITAL CENTER 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 214-20-4588 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23a or 28a-f show permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryler Depertment of Heelth and Mantal Hyglene. Depertment of Heelth and Mantal Hyglene. Interpretation if item 27 is marked other than "natural, or items 23a or 28a-f show mis propriet; if item 27 is marked other than "natural, or items any injury or other traumatic event, the Madical Evanment must be matified at once. 1 Yes 2 No **Funeral Director** MP 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 11. Marital Status Bfack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Symame) 17. Father's Name (First, Middle, Last) tallie ome ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Pelationship (Type, Print) 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Pface of Disposition (Name of 20c. Location cemetery, crematory or other place) 26-05 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FOREST HILL, MD 21050 EVANS FUNERAL CHAPEZ-BELAIR, 3 NEW PORT DR 23a. Pan 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finaf disease or condition resulting in death) END STAGE DEMENTIA **Physician** /Medical Due to (or as a consequence of) Examiner ACUTE THYROCARDIAL ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed RENAL DISEASE END STAGE Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav detached for in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 3 ☐ Probably 4 KUnknown 1 ☐ Yes 2 ☐ No DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 DInpatient 2 ER/Outpatient 3 DOA 28c. fnjury at Work? varai Director: After th filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural Injury 5 Pending investigation 1 🗌 Yes 2 No death. 2 Accident Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funarai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D54736 - 22 - 2001 30. Name and address of person who completed pause of death (ftem 23a) (Type, Print) Dr. KAMEUN AUYEUN 9000 FRANKLIN SQUARE DRIVE, BALTMORE 31. Date filed (Month, Pay 32. Rasistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death s Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City Town, or Location of Death 4c. County of Death **Examiner** 6. Sex (In yrs last birthday) 7. Age 8. Date of Birth (Month, Day **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 KF Days Hours **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic avant, the Medical Examinational Legical Engineering 2009. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funerai Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4X Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Derial 2 Cremation Location - City or Town, State 3 Removal from State ¹ 4 ☐ Donation 5 Cther (Specify) 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final Biliary **Physician** ancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 □ Yes 2 □ No Month Day 4□Pregnant at time of death 5 Other (specify) been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1□Yes 2ZNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No certificate has page 2 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only examiner? Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending Injury 1 🗌 Yes 2 🗆 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer to state and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Meu

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mummel

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31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Year **Physician** RAYMOND 4c. County of Deeth LemoiNe /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AIR ORIEN OR 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** 15 M 2□ F Deys Hours 93 391-03-2095 Director 1912 Iowa Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Harford Maryland Fallston 1 ☐ Yes 2 No 28a-f Director the Medical Examiner must be notifie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò filed within 72 hours efter deeth with 2123 Oaklyn Drive 21047 USA 230 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 5 altimore, Maryland 21215-0020 1 Yes 20No Specify: White Specify: þ 3€ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 General Manager Women's Retail end Mentel Hygie Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 end 2 should be fil ment of Health end Mentel H lant: If Item 27 Is marked out Clement (unk) LeMoine Alice (unk) Lamoureaux 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry K. LeMoine/Son 2123 Oaklyn Drive, Fallston, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: If it any injury or o pnce. 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8-23-05 Hilltop Service Corp. Towson, MD 21. Signeture di Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Part. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a ARTERIOSCLEROTIE CARPIONASCULAR Examiner Physician/Medical Examiner the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760. Due to (or as a consequence of): deteched for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown HYPOTHYROID þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen RENAL INSUFFICIENCY CONGESTIVE HEART FAILURE hes pege 2 certificete 1 ☐ Yes 2/2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifice completely filled in by the funeral director, a Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ဥ Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred Medical Certification: 28c. Injury et Work? 1 DNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Under the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) raus MI 24534 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

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622 S. CIMON AVE, HAVRE DE GRACE,

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32. Registrar's Signature

DHANJANI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year IEWIS **Physician** 2005 AUG EDGAR MULLKIN /Medical 4a. Facility Name (If not institution, give street and number) BALTIMCRE 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER BALTIMORE REHAB AND EXTENDEN CARE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 2 M 2 □ F May11,1920 220-09-8299 85 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 8712 Blairwood Road Itams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 0 1 ☐ Yes 2√ No Specify: Baltimore, Maryland 21215-0036 2 3 Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is markad othar than ury or other traumatic avant, Item Elementary/Secondary (0-12) Painting Painter 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William L. Lewis unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 82 Handworth Way Baltimore MD 21236 Edgar Lewis /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/22/05 BayviewCrematory Baltimore MD Department of Important: If any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 trications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) MULTIINFARCTION Pnysician DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a year ing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by KIONE 1 Tes 3 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 😿 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? al or Attending P safter death. I Diractor: After I Certification: After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier ical (Check only one) To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056508 mo XIANGRONG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Registrar

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31. Date filed (Month, Day, Year)

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Beaus B. Spark

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Richard Thomas McGinnitu 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 8. Date of Birth (Month, Day, Year) Oct. 10, 1933 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months Days Hours Min. Yrs. 215-30-0572 Director 71 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Evanioer must be notified at 1X Yes 2 No Director Maryland Baltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4225 Stanwood Road 21206 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced White. 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then "any injury or other traumatic event, the Me any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker 7th Grade Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Joseph McGinnitu Mary Irene Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Robert McGinnity (Brother) 19717 Five Forks Road, New Freedom, PA. 17349

200 Method of Disposition

| Date | Date | 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) Bayview Crematory 8/25/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee **)**(3331 Brehms Lane, Baltimore, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNYUMONIZ disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 32 DoD Records, þ 1 Yes 2 No 3 Frobably 4 Unknown Be Completed De 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Vital 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 0/ 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 200 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

within 24 hours a To the Funeral D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pobler Durker 9733 H 9733 31. Date liled (Month, Day, Year) 32. Registrar's Signature neste. Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** August 18, 2005 5:30 a Matthews /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manor Care Nursing Home Bethesda Montgomery Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ★M 2 ☐ F 219-64-0778 50 Yrs 1955 Director Bethesda, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show Exacting must be notified at 1 Yes 2 No MD Montgomery Silver Spring Director 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number 1900 Laytonsville Road, Apt. 1302 20910 or Items 23a United States Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2X No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Professional Musician Music 2 permit. Pages 1 and 2 should be file Department of Health and Mentair My important: If Item 27 Is marked other eny injury or other trailments. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joe Princeton Matthews Florence Gero Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Heraujoissus (S. Sue Jackson/ Sister Informant's Name/Relationship (Type, Print) 916 Viers Mill Road, Rockville, MD 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22 1/ 2005 Beltsville, MD Chesapeake Crematory Rapp Funeral and Cremation Services 21. Signature of Funeral Service Licensee m01358 933 Gist Ave Silver Spring MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** TO THRIVE /Medical Due to (or as a consequence of). Examiner IMMUND DEFICIENCY ACQUIRED SYNDROMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit LIVER CANCER attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate 1 Yes 2- No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death 2 Accident the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057124 an, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6530 Democracy Blvd., Bethesda, MD Dr. A. Bao 31. Date filed (Month, Day, Year) AUG 2 3 2005 32. Registrar's Signature State Registrar

		4	For State	State of Maryland	d / Department o			ene g. 2 .005 2	7554
			Registrar Decedent's Name (First, Middle, Last)		Certificate	or Death	2. Date of Death		3. Time of Death
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	/Medic Examin		a. Facility Name (If not institution, give s 5812 S. MARINO)	treet and number)	4b. City, Tov	m, or Location of Deat MARLB	OXO	4c. County of Death	
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	aryland show		Jsual Residence of Decedent 10a. State 10b. County		V, Town or Location UPPER M.	ARI BORI	2	1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the M s or 28a-f	Directo	10e. Street and Number	MARWOOD	10f. Zip Co			g. Citizen of What Cour	dry?
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_	nd 2 stranger tranger		19a_Informant's Name/Relationship (Ty JOHN, MILLEK	(SON)	19b. Mailing Address (S 2305 Mod	VIEBELL	TERR. Y	PALTU, MO	21214
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Balti	permit. Pag Department Important: b any injury o		21. Signature of Funeral Service Licens	" Sico	22. Name and 7	YORK Cor		GREENE FL TMOKE, MARY	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat ne cause on each line.	h. Do not enter the mode of	f dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
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D. Box	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a 9 □ Unknown	al death 3 □Ectopic preg			23d. Date of deliv Month	ery Day Year
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Division	for Attanding after death. Diractor: After	Certification;	3 Suicide 6 Could not be 4 Homicide determined		nome, farm, street, factory,	office	28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
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1	U		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)	NR \$ 103	Flesh	holog tow M.	D20144
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		_ 1	For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of H tificate of L	ealth and Me Death	ental Hygier Reg.		27555
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	/Medic		la. Facility Name (If not institution, g		111.		Location of Death		4c. County of Dea	
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	Funeral				rs. last birthday)	If Under 1 Year		B. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign ountry)
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	ס		Usual Residence of Decedent		0.1. T.					10d. Inside City Limits
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	or 28	Director	10e. Street and Number			10f. Zip Code 20746		10g.	Citizen of What C	
	filed within 72 hours after death with the Maryland Hygiene the than "natural; or Items 23a or 28e-f show ent, the Madical Examination notified at		6810 Pickett Dri					· · · · · · · · · · · · · · · · · · ·	14. Race - Am	
	r des	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	was Decedent of H If Yes, sp <i>ec</i> ify Cuba	ispanic Origin? (Spec n, Mexican, Puerto F	lican, etc.)	Black, Whi	
36	or l	by Fi	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give △ Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: W	nite
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2	filed Hygi other		17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Maid	den Surname)	
an	d be ental ked c	To Be	Clyde R. Cost	enbader			Bess	sie M. Jol	nnson	
Maryland 21215-0036	should Mark	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	Route Number, Ci	ty or Town, State,	Zip Code)
\leq	ith at 1th at 27 is r treu		Bernard Miller	(Husband)	6810) Pickett	Drive Mor	ningside	. MD 2074	46
ર્જ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merial Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28e-1 show amy injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic event.	1	20a. Method of Disposition	20	b. Place of Dispo	osition (Name of matory or other place	D A110115	ate 22. 20c	. Location - City o	r Town, State
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	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a con	sequence of):	CV I	1100	, – –		20001117
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of		Ë	27. Manner of Death	28a. Date of Injury (Month, Day Yea	ar) 28b. Time		ry at	28d. Describe how	injury occurred	
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	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	Z	29b. Signature and title of certifier				se number		Date signed (Mo	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** GEORGE 449 200 /Medical 4c. County of Death 4a. Facility Name (If not institution give street and number, Baltimore Rehab & Extensi 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 XM 2 ☐ F Yrs. 01-31-1914 Virginia Director 218-01-8763 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-1 show 1XXYes 2□No NA Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number filed within 72 hours after death with USA 21215 5424 Nelson Avenue Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or itams 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 X Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Schools Bus Driver 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown Be and Mental Fishers is marked of Pages 1 and 2 should be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If itam 27 is any injury or othar trau 5424 Nelson Avenue Baltimore, MD 21215 Kay Ferrell/ Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 08-22-05 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNDVOWN METASTATI WITH **Physician** ETIOLOGY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death . After Injury 5 Pending 1 Natural 1 Tyes 2 🗆 No after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a To tha Funaral L Fo tha Hospital fill ed 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person

3900

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Brint)

Kave

			For State	State of Ma	aryland	•	irtment of H		d Mental Hyg	-	
	_		Registrer 1. Decedent's Name (First, Middle, Last)				uncate of t	Jealii	2. Date of Dea	ath	5 7 Time to Death
	Physicia			Ann M	orio	artu			August	Day Y	ear 13:00 M
	/Medic Examin		4a. Facility Name (If not institution, give s		- , , ,	^' '7	4b. City, Town, or	Location of D		4c. County of	Death
			Greater Baltimo	re Medi	cal Ce	nter	Tou	Soil		Batt	imore
	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	Min. (Month, Day	h, Year) 1918	Birthplace (State or Foreign Country) Maryland
	ס		Usual Residence of Decedent						Jopev L	,	
	arylar ehow	_	10a. State 10b. County			Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☆No
	the M	Director	Maryland Baltimo:	re		Towso	n 10f. Zip Code			10g, Citizen of Wh	21
	With Ba or	ום	8418-A Charles V	allow Ct				204			5.A.
	deeth ma 2:	Funeral		2. Was Decedent	Ever in U.S.	13. \			? (Specify Yes or No- uerto Rican, etc.)		American Indian,
9	after or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X I If Yes, Give			ryes,specnycuba I⊡Yes 21XINo	n, mexican, P Specify:	uerto Hican, etc.)	Canada.	White, etc.
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21215-0036	d within 72 hours effer deeth with the Maryland jlene. Then "neturet", or Itema 23e or 28e-f ehow Ite Medical Exeminer mast be notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	luring most of	working	16b. Kind of Busin	ness/industry
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	oe filed al Hygid d other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maiden Surname)	
Maryland	iges 1 and 2 should be filed it of Health and Mental Hyg it Itam 27 is marked othe or othar traumatic evant,	٦ ا	William	Guthlei	n				aret	Caro	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type	•			,		r Rural Route Numbe		
a)	s 1 and 2 if Health Itam 27 i		Ellen Pickett 20a. Method of Disposition	_(daughte	20b. Pla	ce of Dispo	Dancrest sition (Name of		Clarksbi	ur Mary 20c. Location - Ci	land 20871
ē	ages ent of th: If If		1 Donation 5 Other (Specify)	emoval from State	1		hatory or other place ${ m dral}$ Cem	· I	8-23-05	Baltimore	e, Maryland
Baltimore,	permit. Pages Department of H Important: If Its any Injury or of once.		21. Signature of Funeral Service License	98	•				eld Funera		
	60550		Leone 1 ter	rane	1 16 0 1 0 0 16		bout yor	<u>k koad</u>	Baltimor	e, Maryla	and 21212
	1000		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	-			g, such as car	diac of respiratory an	rest,	Approximate Interval Between Onget and Death
	Physician /Medical		disease or condition resulting in death)	 Due to (or as	a conseque	nce of	onia				days
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687	ificate g phy: as the	edlcal		Compressor -							
Вох	h cert endin	an/M	230. Was decedent pregnant	3c. If yes, outcome 1□Live birth	of pregnance		Ectopic pregnancy			23d. Date of	
O. B	that the death certifii ed by the attending p detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (specify)			Month	n Day Year
0	that th		Part II. Other significant conditions con	tributing to death b	out not result	ina in the u	nderlvina cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
Vital Records,	uires tha signed Id be de	d by		3			,		1 □ Y	res 2 □ No 3	☐ Probably 4 Minknown
CO	w requir s been si should	lete							24a. Was		re autopsy findings available
Be	The law requires ate has been sign page 2 should be	Completed							— autop perfor 1 ★ Yes	rmed? dea	or to completion of cause of th? Yes 2 \(\sum \) No
ta		Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check only or		
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n		lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		8b. Time of Injury	28c. Injury Work	rat ⊲? Yes 2 ∐ No	28d. Describe h	ow injury occurred	
Division of	deat ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	ury - At hom	ne, farm, str	eet, factory, office	143 2 1140	28f. Location (S	Street and Number	or Rural Route Number,
Ö	alor A s efter al Dira	Certification:	4 Homicide determined	building, et	c. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	m, State)	
	To the Hospital or At within 24 hours efter or To the Funaral Diract completely filled in by	edical ((Check only 2 Medical Evamir	tar: On the hacie o	f avaminatio	on and/or in	actigation in my or	sinion death c	lace, and due to the o occurred at the time, o	data and place, one	d due to the equec(c)
	ro the	Med	29b. Signature and title of certifier				29c. License	number	4	29d. Date signed (/	Month, Day, Year)
	,		> Kobert M	Filera	w n	D	D.	2771	40	198/20	12005
	15		30. Name and address of person who co	mpleted cause of c	death (Item 2	23a) (Type,	Print)	- / /	C: .	7	1
	17		Robert A. Pale	rmo, m	(D.	0710	North (harle	s street	, lowser	1 MD 21204
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2, 3, 2	005 Facility	ars Signatu	J A	barles				Month, Day, Year) 0/2005 A MD 21204

			1 - For State Registrar	State of Maryla	•	artmen rtificat			and M	-	giene Reg. No	2005	5 2	7558
П	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of De. August		200 ⁵ 5	ar 3.	Time of Death
	/Medic	al	Ryan Joseph Mux 4a. Facility Name (If not institution, give	phy street and number)		4b. City.	Town, or	Location o	of Death	nagase		County of D		a. W
ige.	Examin	er	Johns Hopkins Hos				ltimo					n/		
	Funeral Director		5. Social Security Number 6. Se 215–02–2506	7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da August 2	, 198	9. I B2 M	Birthplace Country aryla	(State or Foreign
	ow ow		10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. lr	nside City Limits
	a-f eh	ctor	Maryland Baltin	nore	Cub Hi	11							1	∐Yes 2√∑No
	or 28	Dire	10e. Street and Number			10f. Zip		4071			10g. Citiz	en of What		
	eath w	eral	2602 Meadowland Co	12. Was Decedent Ever in	115 13	Was Decer		1234	nin? (Sne	acify Ves or No	. 1	US 4. Race - A		udian
(0	r item	Fun	1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No					, Puerto	ecify Yes or No Rican, etc.)		Black, W		iorair,
93	72 hours after death with the Maryland natural; or itema 23a or 28a-f ehow dical Examinar must be natilied at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2L X No	Specify:				Specify:	Whi	te
15-0	n 72 h	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usua kind of wo DO NOT us	rk done d	uring most	of worki	ing	16b. Kin	d of Busine	ss/industry	у
12	l withir lene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		la n age			rdir	ator		Groce	ry	
bu	at Hyg Lother Vent,	BeC	17. Father's Name (First, Middle, Last)		- 1					(First, Middle,		Sumame)		
ylaı	ouid be Mental arked o	To E	William Joseph Mu							rie Bro				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other then "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinatory and the natified at ange.	P	19a. Informant's Name/Relationship (7 Mr. William J. Murphy,			-				il Route Numbe	-		s, Zip Code	θ)
	Healt tam 2 other		20a. Method of Disposition		o. Place of Dispo	osition (Nar	ne of		W-150-10-10-10-10-10-10-10-10-10-10-10-10-10	ate		ation - City	or Town, S	State
OE.	Pages lent of nt: if i		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 🖟 Other (Specify	Removal from State	cemetery, cre. 111top Ser				8/26	/2005	Towso	n Mer	/land	
Baltimore,	permit. Departm Importa any inju		21. Signature of Farral S 11. Leen:	11 / 1	2:	2. Name an	nd Addres	s of Facility	у					21204
8	8959		23a. Part1. Enter the disease, or comp	k, w						, Inc. 10		irk Road		
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P.O. Box 6	the death certific by the attending p ached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of Month	delivery Day	Year
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Division	5 # E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st.	reet, factory	y, office			281. Location (Street and Number or Rural Route Number, City or Town, State) 300 Baston St 2 5. Potomuc St - Buttimore, MD			H2 5.	
	To the Hospitei within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ★ Medical Exem	vsician: To the best of my iner: On the basis of exam	knowledge, deat iination and/or in	h occurred ivestigation	at the tim , in my op	e, date and pinion, deat	d place, a th occurr	and due to the ed at the time.	cause(s) a	and manner	as stated.	
	o the ithin 2 o the omplet	Med	29b. Signature and title of certifier	and manner stated.		290	c. License				29d. Date	signed (Mo	onth, Day,	Year)
	F 3 F 8		front Bara	thall MA			(OCME			Aug	ust 22	2, 20	05
ı	10 7		30. Name and address of person who can be so that the same and address of person who can be so that the same and the same	completed cause of death (Item 23a) (Type,	Print)	D.	- C:		D - 7 · ·		Ma 7	1	21 201
_						TTT	reni	1 Str	eet,	Baltim	ore,	Mary.	Land .	Z1ZUI
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2. 3. 2	32. Registrar's Si		hart								

Registrar

DR. DAVID DUNN,

AUG 2 3 2005

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

BAL AIR, MARYLAND

615 W. MACPHAIL ROAD,

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. Mg. 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** ROBERT EDWIN NOSS AUGUST 20. 2005 0300 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 7519 OLD BATTLE GROVE RD DUNDALK Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours M 2□ F Director AUG 10, 1937 W. VA 234**.**58.0476 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28e-f show treumetic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE DUNDALK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23e 7519 OLD BATTLE GROVE RD. 21222 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. filed within 72 hours after Yes 2 No Tres, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL STEEL WORKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental F snt: If item 27 is marked ol NELLIE GUTHRIE ٥ EARL R. NOSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7519 OLD BATTLE GROVE RD. DUNDALK, MD 21222 item 27 i LINDA NOSS (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation XXX Removal from State = 5 Department of Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) SHADY GROVE CEMETERY \ 8.24.2005 BRUCETON MILLS, WV GREGORY FINE FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or andition resulting in a th) Priysician Due to (or a a consequence of): /Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by Yes 2□No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1□ Yes XX^{No} To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 🗌 Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P Residence 6 Other (Specify) 28d. escribe how injury occurred Manner of Jeal this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) MYO CHAN 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			1 = For State Registrer	-	artment of Health and M rtificate of Death		2005 27561
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici		Roger William Pr	.ovost		Month August 1	9, 2005 10:45am M
	/Medio Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death	11008	4c. County of Death
1	LAGITI	Ŭ.	Greater Baltimore M	ledical Center	Towson		Baltimore
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
	Director		130 40-4128	□ F 56 Yrs.		Aug. 28,	1948 New York
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Marylan f show ied al	lo.	Maryland Baltimore	B	Saltimore		1 ☐ Yes 2 ☑ No
	r 28e	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	h with	al D	2128 Vailthorn Roa	d	21220		U.S.A.
	deat	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
98	or it	y.F.	1 Never Married 2 Married 1	∃Yes 2. XNo Yes, Give	1 ☐ Yes 2 ☑ No Specify:	, ,	Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then 'neturel', or items 23a or 28e-f show ont. the Mcdical Examiner must be notified at	d by		ear or Dates:	dent's Usual Occupation	16	Bb. Kind of Business/Industry
7	in 72	Completed	15. Decedent's Education (Specify only highest grade com	oleted) (Give	e kind of work done during most of worki DO NOT use retired)	na .	altimore County
712	the st	mo	Elementary/Secondary (0-12)	1)llege (1-4or 5+) 5+ T	eacher		ublic Schools
	othe vent.	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	iden Sumame)
/lar	uld be Menta Menta rrked	To E	Elmore Lloyd Prov	ost	Grace	U. Cha	pple
Maryland	2 sho and / is me	11.3	19a. Informant's Name/Relationship (Type, Pr		ing Address (Street and Number or Rura		
	and lealth m 27 her tr		Mrs. Donna Provost		Vailthorn Road, B		MD 21220 C. Location - City or Town, State
or	Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene. Int: If item 27 is marked other then "neturel", or items 23a or 28e-f show int: If item 27 is marked other then "neturel", or items 23a or 28e-f show int of the reunalic event. Ite Macinal Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Remov	aritom state _	matory`or other place)		
Baltimore,	F F F F		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Crematory $ 8/23/2 $ 2. Name and Address of Facility Sch	imunah E	Baltimore, Maryland
Ba	permit. Departr Importe any inju		21. Signature of Automotive Cities 1366		705 Belair Rd., Ba		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	se on each line.		or respiratory arres	t, Approximate Interval Between Onset and Death
	Physician	0.0	Immediate Cause (Final disease or condition	CEREBRAL	ANOXIA	10-2	Onset and Douth
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	AL INFARCT	1005	
l.		i i	Sequentially list conditions, b	Due to (or as a consequence of):	ME INMICE	(0/)	
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	CARDIAC	ARREST		
oʻ	exec an an	Еха		Due to (or as a consequence of):			
8760,	The faw requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d	RESP ITOIZ	1 FAILURE		
9	that the death certific ed by the attending p detached for use as		IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of delivery
Вох	atten for u	by Physiclan/Me	in the past 12 months?	Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		Month Day Year
o.	the d y the iched	ysi		Unknown			
<u>α</u>	res that igned b be deta	y PI	Part II. Other significant conditions contribut	ing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rds	w require been sig should b	edt				1 🗀 Yes	2 No 3 Probably 4 Unknown
Records,	ie taw requ has been ge 2 shoult	Completed	<u> </u>			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	The tate has page	E O				performe	ed? death? ZNo 1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			n (Check only one)	***
of \	Physi this c al dire	은	1 ☐ Yes 2 No Hospita	1 Impatient 2 EN Outpatie		me 5 Residen	ce 6 Other (Specify)
uc	ling After fune	lon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred
Division	Attending it death. ector: After by the fune	flca	3 Suicide 6 Could not be	e. Place of Injury - At home, farm, s			et and Number or Rural Route Number,
Ö	tel or a ster al Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town,	State)
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Madicel Examiner: C	: To the best of my knowledge, dea on the basis of examination and/or in nd manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	1 .00.0	29c. License number		d. Date signed (Month, Day, Year)
	15		> Jams > £	frioller	D601793	78 6	18-20-2005
	10			ed cause of death (Item 23a) (Type	, Print)	- 0-5	Tancas MA asasi
	1,0		JAMES K. SMOLEN	32 Registrate Standburg	LONA NUE JUIT	5 202.	100020H MD 71.70
	Sta Regist		31. Date filod (Month, Day, Year) ALLG 2 3 2005	Sz. Jagistrai s Signature	nadi		18-20-2005 Towson, MD 21204

Provost, Roger

			Please *	, .	Indelible Ink. Ensure A	=	
		-	For State Registrar	•	epartment of Health and Nentificate of Death	Mental Hygier Reg. N	
	Di		Decedent's Name (First, Middle, Las.	"		2. Date of Death	3. Time of Death
	Physicia /Medic	al	George	D. tayne	4b. City, Town, or Location of Death	Aug /	9 2005 7 00 F, M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	Timonium		BALTIMORE
	Funeral		5. Social Security Number 6. Se	W		8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent			19-1-0	1 New Krsey
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f show important: If item 27 ie marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event. The Midfield Examinar rust be mailfied at once.	jo	10a. State 10b. County	10c. City, Town	Bol Air		10d. Inside City Limits 1 ☐ Yes ► No
	or 28a-	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	s 23a	Frai	620 Friar	12. Was Decedent Ever in U.S.	21014	pecify Yes or No-	14. Race - American Indian,
(0	after de or Item niner		11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
21215-0036	ural', d	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Decedent's Usual Occupation	16h	Kind of Business/Industry
215-	in 72 l	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		(Give kind of work done during most of wor life. DO NOT use retired)	king	1
212	ed with ygiene ner tha	Com	12,) /	Manager 18 Martings No.	ne (First, Middle, Maio	tutomotive
Maryland	d be fill antal H ced otf c even	To Be	17. Father's Name (First, Middle Last)	Payne	Macaa	of T	nunlas
aryl	should land Men e marke	ĭ	19a. Informant's Name/Relationship (7	174	Mailing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip Code)
	l and 2 fealth a		Jeanne Pays 20a. Method of Disposition		Disposition (Name of		Location - City or Town, State
nor	ant of H it: If ite y or ot		1 Burial 2 Cremation 3 * 4 Donation 5 Other (Specify	Removal from State cemeter	Disposition (Name of y, crematory or other place)	-77-15 F	OREST HILL MD
altimore,	permit. P Departme importan any injur		21. Signature of Funeral Service Ligen	CD+tO-	22. Name and Address of Facility	ROST HU	LL, MD 21050
8	50 E 20		Stately 4.	Sacriotais	EVANS FUNERAL C	HAPEC-B	ELAIR. 3NEW PORT DR
	Les el in		Immediate Cause (Final		not enter the mode of dying, such as cardiac	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aLUNG CANCER Due to (or as a consequence	of):		
	Examiner	70	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):		
	nd nd transit	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events		- /		
,00		Ä	resulting in death) Last	Due to (or as a consequence	of):		
68760,	icate b physic s the b	dlca		d			
Вох	Physicien: The law requires that the death certificate be exertificate has been signed by the attending physician are this certificate has been signed by the attending physician are director, page 2 should be detached for use as the buriat-in	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
	that the death ed by the atte detached for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
P.0	that the		Part II. Other significant conditions of	ontributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	v requires been sign should be	ed by				1 🗆 Yes	2 No 3 Probably 4 Wallnknown
eco	law renas bee	ompleted				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
al B	icien: The L certificate ha rector, page	O	GE Was easy referred to modical		26 Place of De	1 ☐ Yes 2 🗶 ath (Check only one)	
Γ×	ing Physicien: n. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 Inpatient 2 ER/Ou	The state of the s		6 TOther (Specify) HOSPICE
n o	ding Ph J. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	njury occurred
Division of Vital Records,	death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not b	e 290 Place of Injury - At home for			t and Number or Rural Route Number,
Div	tel or / s after el Dire ed in b	Certi	4 [] Homicide			City or Town, S	
	Hospl 24 hour Funer tely fills	edical (29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exam	nysician: To the best of my knowledge niner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and placed or investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
_	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Med	29b. Signature and title of certifier	and mariner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
	1			/	D43725		8/22/05

State Registrar

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 3 2005

ORIGINAL

RIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

ORIGINAL

		1	For State Registrar	State of Maryland / D	epartment of Health Certificate of Deatl		giene ag. NO 105 27561.
					Jerimoate of Boats	2. Date of Dea	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Wi Lliam	Clinton	Pritche		18 2005 06:15 p M
	Examin	er	a. Facility Name (If not institution, give st Baltimore Kenabilitat	reet and number) Extended	4 b. City, Town, or Location Baltimo	_	4c. County of Death
	Funeral		Care Center 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Year If Under	er 24 Hrs. 8. Date of Birt	h 9. Birthplace (State or Foreign
	Funeral Director			^{M 2□ F} 79 Y	rs. Months Days Hours	Min. (Month, Day July 11	, 1926 Maryland
	_	t	Usual Residence of Decedent				
	yland yland		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Mar Mar	tor	Maryland Baltimo	re T	imonium		1 ☐ Yes 2 📉 No
	r 28g	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	h wit	al D	1 Gandson Court, u	nit 202	21093		USA
	deat	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland liene. Tithen "naturel", or Items 23a or 28a-f show The Madical Exam her must be mutified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give	1 ☐ Yes 2 🔀 No Speci		Specify:
21215-0036	hour:		15. Decedent's Educ	Year or Dates:	Decedent's Usual Occupation		White 16b. Kind of Business/Industry
45	C	Completed	(Specify only highest grade	completed)	(Give kind of work done during m life. DO NOT use retired)	ost of working	
12	within iene then "	inc.	Elementary/Secondary (0-12)	College (1-4or 5+) 2. S	alesman		Printing Equipment
d 2	at the	Ö	17. Father's Name (First, Middle, Last)			ther's Name (First, Middle,	
Maryland	0 ta 20 0	To B	James Clinton	Pritchet	t	Grace	Simmons
ary.	s 1 and 2 should f Health and Men item 27 is marke other treumatic	-	19a. Informant's Name/Relationship (Typ	e, Print) 19b.	Mailing Address (Street and Nun	nber or Rural Route Numbe	er, City or Town, State, Zip Code)
	D = 2.1	1	Mary Pritchett/Wif	e1	Gandson Court,	unit 202, T	Timonium, MD 21093
re,	s 1 ar		20a. Method of Disposition	cemeter	Disposition (Name of y, crematory or other place)	8/23/05	20c. Location - City or Town, State
Ë	Pages nent of h ant: If ite ury or o		1 ▼Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	Dulane	ey Valley Mem.		Timonium, Maryland
alti	permit. Page Department of Importent: If eny injury or once.		21 Sign that of Fun ral Service License	Elst	22. Name and Address of Fa	cility	ılaney Valley Inc.
0	99E 98		Bryan W. Clary		10 W. Padonia	Road, Timor	nium. MD 21093
			23a. Part1. Enter the disease, or complice shock, or heart ailure. List only on	cations that caused the death. Do re e cause of each line.	not enter the mode of dying, such	as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause Final disease or condition	Acute in	yo cardial	· ufarct	
	/Medical		resulting in death)	Due to (or as a consequence	of): 7	· ·	The second secon
	Examiner		Sequentially list conditions, b		-0.		
	ad Sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	or).		
· _	cate be executed physician and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence	of):		
8760,	be es	E E					
387	phys s the	edical	0	•			
Box (leath certific attending p	/M	IF FEMALE: 2.3b. Was decedent pregnant	3c. If yes, outcome of pregnancy	- 55		23d. Date of delivery
B	w requires that the death certiff been signed by the attending should be detached for use as	by Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		Month Day Year
P.O.	oy the	hys	9 Unknown	9□ Unknown			
	s thai	y P	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause given in Pa	ATT I	tobacco use contribute to the cause of death?
rds	quire an sig		Dement	14			Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown
Records,		Completed	Ansiexi	<u> </u>		24a. Was	prior to completion of cause of
Ä	sicien: The law certificate has b irector, page 2 s	E				perf	ormed? death? 2 No 1 Yes 2 No
of Vital	rtiffica	Be C	25. Was case referred to medical examiner?			lace of Death (Check only	one)
f <	S 0 0	5	1 ☐ Yes 2 DoNo	lospital: 1 ☐ Inpatient 2 ☐ ER/Ou			idence 6 □Other (Specify)
0	ding Phy h. After thi funeral	ü.	27. Manner of Death 1 ②Natural 5 □ Pending		Time of 28c. Injury at work?		how injury occurred
Ö	endir sath. or: Al	atle	2 Accident investigation		M 1 ☐ Yes 2		(0)
Division	al or Attending F s after death. I Director: After id in by the funera	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		(Street and Number or Rural Route Number, own, State)
	itel ours af	Se		<u> </u>		and place, and due to the	a gauge (a) and manner as stated
	Hosp 24 hol Fune stely fi	edical	(Check only 2 Medical Exami	and manner stated	nd/or investigation, in my opinion,	death occurred at the time	, date and place, and due to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	1	29c. License numb	per	29d. Date signed (Month, Day, Year)
	F 3 F ŏ		1 / / / /	1 sier 1	nd 04	,7804	08/18/2005
	111		30. Name ind address of person who co	ompleted cause of death (Item 23a)	(Type, Print)		
	1171		A.MRDLUIEC	3900 Lock R	even Blod	Balhine.	e MD 21218
	_{se} St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Anaelis		29d. Date signed (Month, Day, Year) 08/18/2005 2 MD 21218
	Regis	ror	■ ALIC 9 3 7HH5	ENGLACI AS	A STATE OF THE PARTY OF THE PAR		

32. Registrar's Signature

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 2005 **Physician** 04:18aM Forrest H. Randall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring 8413 Park Crest Dr. Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1 XM 2 ☐ F 007-22-2513 Maine 04-05-1928 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if item 27 is marked other than """ any injury or other treumer: 21742 129 Stanford Rd. USA items 23e Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married XYes 2 □ No White 1☐ Yes 2☐ No Specify: If Yes, Give Year or Dates: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Flight Control Engineer Defense Contracts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Rose Welch Harvey Day Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Stanford Rd. Hagerstown MD 21742 Karrie L. Loucks/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Chesapeake Crematory 08-18-2005 Beltsville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Service
933 Gist Ave Silver Spring MD 20910 Rapp Funeral & Cremation Se 933 Gist Ave Silver Spring

23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 14 years Pnysician Non Hodgkins Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rsician and a burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2x ☐xNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s 1 ☐ Yes certificate 2 🔀 No Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 2 this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08-16-2005 D35996 1 ma 301 me and address of person with propleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

AUG 2 3 2005

Box 68760,

P.0.

Dr. Linda Burrell 2730 University Blvd #400 Wheaton MD 20901

32. Registrar's Signature

			State of Mary		epartment Certificate				~	005	27567
			Registrar 1. Decedent's Name (First, Middle, Last)		7.1.1	0. 5		2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic		Mildred	w. Koad				August	22	2005	4:55 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital			own, or Lo $1 { t time}$	ocation of Death	/	4c. C	ounty of Death N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (Ir	n yrs. last birth	Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March	Year)	9. Birthpi Coun	lace (State or Foreign
	Director	-	239-34-1643 1□ M 2€XF Usual Residence of Decedent	78 Y	rs.			March 3	31, 1	927 N.	Carolina
	yland how		10a. State 10b. County 10	Oc. City, Town		·			•	10	Od. Inside City Limits
	8a-f s	Director	Maryland N/A		Balt:		=	1.	On Citizo	on of What Coun	1XXYes 2 □ No
	with the		10e. Street and Number 4140 Falls Road		10f. Zip C		211	'	og. Cilize		USA
	death	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decede	nt of Hisp	anic Origin? (Spe Mexican, Puerto F	cify Yes or No-	14	Race - Americ Black, White,	
2	be filed within 72 hours after death with the Maryland all Hygiene. And Hygiene. I have the district than "natural", or terms 23a or 28a-f show other than "natural" Ename are minist to rediffice and event. The Maulical Ename are minist to rediffice and another than the profile of all the second control of t	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 Mo If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:	, , ,	S	pecify:	white
	2 hour		15. Decedent's Education	16a. I	Decedent's Usual	Occupati	on	()	16b. Kind	of Business/Inc	dustry
7	ithin 7. ne. nen "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		(Give kind of work life. DO NOT use Homemake:		ing most of workir	ig		In own	home
V	filed w Hygier ther th	e Cor	8 17. Father's Name (First, Middle, Last)		TOMEMAKE.		8. Mother's Name	(First, Middle, I			
<u></u>	lid be flental liked or	To Be	Joseph Robert Williams				Mary	France	es Yo	W	
viary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exertains in mail be retified at ange.		19a. Informant's Name/Relationship (Type, Print) Iran L. Roach Son		Mailing Address (140 Falls			Route Number			Code) 1211
ָה ה	s 1 and f Healt item 2 other		20a. Method of Disposition	20b. Place of	Disposition (Name	e of ner place)	D	ate	20c. Loca	ation - City or To	wn, State
Dallimor	Page ment o ent: If ury or		1 ☐ Burial ※☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify)		Cremator		8/23/	/2005	Cato	nsville	, MD
חשו	permit. Departi Importi any inj		21. Signature of Puneral Service Licensee		Bur ee-	Address Hens:	^{of Facility} S-Seitz I Koau ba.	Tuneral	Home Mar	Inc.	21211
T	34		23a. 1. Inter the distalse, or complications that caused the shock, or heart failure. List only one couse on each line.	e death. Do n						-	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Vascul			0		4	Onset and Death
	/Medical Examiner		Due to (or as a co	onsequence o	19: 19:601						15 1000
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9/00,	cate be executed physician and s the burial-transit	al E	bus to (or as a co	Crisaquerica o	1		f				,
0		fedical	d.								
X O D	w requires that the death certifi been signed by the attending should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of past 12 months?	Fetal death	3 ☐Ectopic pre				23	d. Date of delive Month	ry Day Year
	the de y the a iched f	ysic	1 Yes 2 No 9 Unknown	10 Of Ceath	5 Other (spe						
7	requires that the leen signed by th hould be detache	by Pł	Part II. Other significant conditions contributing to death but n	not resulting in	the underlying car	use given	in Part I.				ne cause of death?
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VIII	en: Ti tificate tor, pa	O	25. Was case referred to medical			2	26. Place of Death		2 X No	1 🗆 Yes	2X No
010	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 💢 No Hospital: 1 💢 Inpatient	Control of the Contro	tpatient 3 DOA		4 Nursing Hor				1)
	ding P. After t	tlon:	27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Young)	/e <i>ar</i>) 28b. T	ime of 28 njury M	c. Injury a Work?	ut 2 es 2 □ No	28d. Describe h	ow injury	occurred	
UNISION	Attender deatler dector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, far				28f. Location (S City or Town		Number or Rura	l Route Number,
5	ital or irs afte rel Dir led in	Cert									
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of management of the basis of examiner: On the basis of examiner and manner stated	xamination and							
	To th within To th comp	Me	29b. Signature and title of certifier			License				signed (Month,	
	(30. Name and address of person who completed dause of deat		A	Ta	43891	46/	tuge	not 22	2005
_	·X		30. Name and address of person who completed dause of death Jennifer L. Pfaur	(item 23a) (Type, Pnnt)	vion	Memo	nal t	tosp	rital,	MD
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	Type, Print)				v	,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 16, 2005 **Physician** 12:30p M ISABEL SPAULDING ROBERTS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 1310 BOLTON STREET | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. J U L Y 1 0, 1911 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 5. Social Security Number 216-68-3629 **Funeral** CALIFORNIA 1 ☐ M 2 1 ☐ F 94 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Mcdical Exprimer must be notified at T☐Yes 2☐No BALTIMORE MD Director 10f. Zip Code 21217 10g. Citizen of What Country? 10e. Street and Numbe TISA 1310 BOLTON STREET death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Intropriant: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modical Experimentage. 1 Yes 2 X If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: Specify: WHITE à 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ART HISTORY ART HISTORIAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HELEN M. ARMSTRONG MOREIL B. SPAULDING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 7 ST. PAUL STREET BALTIMORE, MD 21202 attorney FREDERICK KOONTZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial **Cremation 3 ☐ Removal from State BALTIMORE, MD 8/19/2005 GREEN MOUNT * 4 □ Donation 5 □ Other (Specify) JENKINS & SONS CO. 22. Name and Address of Facility HENRY W. 21. Signature of Funeral Service Licensee Sonto 16924 YORK RD. MONKTON, MD. 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 16 Mos. 2 V9855 IVE Physician disease or condition resulting in death) /Medical onsequence of) Due to (or as Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner ig physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has to autopsy performe 2 1 No certificate 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other. 5 Nesidence 6 □Other (Specify) 1 Inpatient 4 Nursing Home 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ည this After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 No 1 Tyes 2 Accident Director: / 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 002512 th (Item 23a) (Type, Print) 30. Name and address of person who 10 MEDICAL MARK M. stear's Signature 31. Date filed (Month, Day, Year) 32. Reg State AUG 23 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 1:20 pm MILLS ROWSEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** RIVERSIDE BELCAMP HARFORD ORIEN If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗙 F Yrs. Director 217-09-4818 89 Maryland Aug. 21, 1915 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Old Fallston Road 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Completed by I 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carl Edward Carter Bertha Catherine Ison ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ai Impo ent: If item 27 Is any injury or other treu 851 Wheel Road, Bel Air, Maryland 21015 Nancy M. Sheetz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdns. 8-23-05 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature / Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only myocardial in Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): sequence of):

Physician /Medical Examiner

rel', or Items 23e or 28e-f shov Examiner must be notified at

"naturel"

f Health and Mental Hyglene. Item 27 Is marked other than "natur other treumatic event, the Marical

Baltimore, Maryland 21215-0036

page Be 2 s after deau...
el Director: After th Certification:

Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I					
25. Was case referred to medical examiner?		26. Place					
e 27 Mannor of Dogsh	20a Date of Injury 20h T	ima of ODa Injury of					

1 Natural 2 Accident 3 Suicide 4 Homicide

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Medical

uentially list conditions, A, leading to animodate se. Enter Underlying use (Disease or injury initiated events utting in death) Last	b. Oue to (or as a cond
ming in Voucif Last	Due to (or as a cons
EMALE:	23c. If yes, outcome of pre

5 Pending investigation 6 Could not be determined

23c.	If yes, outcome of pregnancy
	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat
	4 Pregnant at time of death
	9□ Unknown

23d. Date of delivery Month Day

Year

23e. Did tobac	co use cor	tribute to the cau	se of death?
1 🗆 Yes	2 No	3 Probably	4 Unknow

	24a. Was an	24b.	Were autopsy fir	ndings available				
	1 Tes	2 No	3 Probably	4 Unknown				
23e. Did tobacco use contribute to the cause of death?								

	11103 240	740 10193	
ath (Ci	heck only one)		
Home	5 Residence	e 6 ☐Other (Speci	ify)

			20. Flace of Death (Orieck Shiry She)							
Но	spital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other:	4 Nursing H	lome	5 Residence	6 ☐Other		
	28a. Date of Injury (Month, Day Year)			Injury at Work?		28d.	. Describe how inj	ury occurred		
1			M	1 Yes	2 🗆 No					

26. Place of De

Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)

Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigand manner stated.		
Signature and	title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

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. Signature and title of certifier		29c. License number	29d. Date signed (Month
DUN	My	D27975	A /21/03

5 1011		
Nam and address of person who com	pleted cause of death (Item 23a) (Type, Print)	

or death (Item 23)									
0 6	15	mai	Chail	nd	Arel	Ain	Mn	210,	Ĵ
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Registrar

31. Date filed (Month, Day, Year) AUG 2 3 2005

within 24 hours a To the Funerel C

			State of Maryland / De	partment of Health	•	
				ertificate of Deat	110	9.N2005 27570
П	Physici		1. Decedent's Name (First, Middle, Last) Dorothy Theresa Reese		2. Date of Death	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	on of Death	4c. County of Death	
			3508 Back Point Court, Unit 1D	Abingdon		Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdom) 76 Yrs	Months Days Hours	s Min. 8. Date of Birth (Month, Day, Feb. 6,	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary a-f sho	tor	Maryland Harford Abingo	lon		1 ☐ Yes 2 🔯 No
	ith the	Direc	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	eath w	erai	3508 Back Point Court, Unit 1D 11. Marital Status 12. Was Decedent Ever in U.S. 1	21009	Origina / Constitution on No.	USA 14. Race - American Indian,
9	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Examinational be notified at	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give	3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		Black, White, etc.
003	ural',	d by	Year or Dates:	1 ☐ Yes ZZQNo Specii		specify: White
21215-0036	n "nat	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during m e. DO NOT use retired)	nost of working	6b. Kind of Business/Industry
212	er tha	Com		stomer Service		Banking
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic avent, the Medical Examiner must be notified at an ance.	Be	17. Father's Name (First, Middle, Last) Louis William Teller		ther's Name <i>(First, Middle, M</i> Teresa France:	
aryl	should nd Me r mark umatic	To				City or Town, State, Zip Code)
	and 2 salth a n 27 is		Jim Reese/Son 20	08 Haynes Court		
Baltimore,	Pages 1 nent of He int: if iter iry or oth		TODATAL 2 CONTINUES 3 CHANGOVALITORI STATE	sposition (Name of crematory or other place)	1	Oc. Location - City or Town, State
Ħ	artmer ortant: injury		' 4 □ Donation 5 □ Other (Specify) 21. Signification of Fundal Service Accesses	Ly Redeemer		Baltimore, MD
Ba	permi Depa impo any ii		Chald a Engle &	McComas Funer		don, Maryland 21009
	8.		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of aying, such a	as cardiac or respiratory arre	st, Approximate Interval Between
	Physician /Medical		disease or condition resulting in death)	estinal he	workage	Onset and Death
ľ	Examiner		Due to (or as a consequence of):			
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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8760,	cate be executed physician and the burial-transit	icai E	d.			
9	intificating physics as the	9	IF FEMALE:			
Вох	eath certific attending pl for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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s, P	es this	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Par	rt I. 23e. Did toba	acco use contribute to the cause of death?
ord	w requir been si shoutd	eted	None		1 🗆 Yes	
Records,	he taw e has I	Completed			24a. Was an autopsy perform	prior to completion of cause of death?
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of V	Physic this ce al direc	ပ္	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	tient 3 DOA Other: 4 I	14	nce 6 Other (Specify)
ono	Attanding Physician: r death. ector: After this certifics by the funeral director, i	tion:	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 1 Accident investigation		28d. Describe how	w injury occurred
Division	Attanding or death.	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre	eet and Number or Rural Route Number,
Ö	ital or ins afte ral Dire	O	building, etc. (Specify)		City or Town,	Srare)
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date investigation, in my opinion, d	and place, and due to the car leath occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License numbe	er 29	d. Date signed (Month, Day, Year)
)	/		Bernard & Gran MD, DME	+00140	206 C	lugust 21, 2005
	5		39 Name and, address of person (tho completed cause of death (item 23a) (Type RFRWAA)	POIR HOLAT	BIRd AVE	BALTO Md 21772
	Sta		31. Date filed (Month, Day, Year) AUG 2 3 2005	refer	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	all with the
	Regist	ar	HOU IS I LOUD PORT SHE JOB			

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178. State of Maxyland / Department of Health and Mental Hygiene

			1 - State Amend Item Registrar	18 per th	3847 9-6- (Certificate of	Death	vielitai i iy	Reg. No	005	27571
	Dhysioi	20	1. Decedent's Name (First, Middle, L	ast)				2. Date of Do	Da	y Year	3. Time of Death
	Physici /Medic		Catherine An	n Sandy				August	17,	2005	7:15 a ^M
	Examin		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Death	1	40	. County of Dea	th
			7805 Hamilton S			Bethe				ontgome	
ı	Funeral Director		270-28-1322	Sex 7. Ag 1 M 2 TF	e (In yrs. last birth	day) If Under 1 Year Months Days		8. Date of Bi (Month, Di May 22	irth a <i>y, Year)</i> 2 , 1	9. Bir 931 Oh:	thplace (State or Foreign ountry)
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	sho	5	OHIO Wood	n ·		ing Green,					1,□Yes 2□No
	the N 28a-f	ect	10e. Street and Number		DOWL	10f. Zip Code			10a Ci	tizen of What C	<u> </u>
	with	늅	1049 Lindenwood	Lana		4340	12		_		·
	eath	era	11. Marital Status	12. Was Decedent	Ever in U.S.			pecify Yes or N		ited St	
Maryland 21215-0036	gos 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Ia marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Examination or other traumatic event, the Modical Examinations.	by Funeral Director	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub		o Rican, etc.)		Black, Whi	te, etc. 7hite
5-0	72 ho	etec	15. Decedent's (Specify only highest of	Educatio n rade completed)	16a. [Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of wor	king	16b. K	and of Business	/Industry
21	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use retire Teacher	od)		1	7d	
7	ed w ygier ner th	S		4		Teacher		(F)		Education	on
Ē	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name (First, Middle, Lat		William	O'Farroll	Sarah C		e ^M Co	le ^{mame)}	
3	should be and Mental a marked o umatic eve	2	Thomas O'Farr						101E	T 0: .	7. 0. 1.)
Nar	12 sho h and 7 la mu rraumi		f9a. Informant's Name/Rélationship Lisa Sandy/Daugh			Mailing Address (Stree					
	Health Health tem 27		20a. Method of Disposition			05 Hamilto		Road, E	$\overline{}$	esda, MD ocation - City or	
0	ges If of H		1 Burial 2 Cremation 3			Disposition (Name of , crematory or other pla	¹ Ω / 1	8/05			
ţ	nit. Parantmen ortant: Injury		`4 □Donation 5 □Other (Spec		Chesap	eake Crema	Lory	0705	ье	1tsvill	eş. MD
Baltimore,	permit. Pages. Department of h Important: If ite any Injury or of		21. Signature of Funeral Service Lic	2	m01358	Avenue S	eral and ilver Spr	ing, MD	-20	ervices 910	933 Gist
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each li	the death. Do no	ot enter the mode of dy	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Meta	static C	ancer of U	nknown Pr	inary			Onset and Death
	/Medical		resulting in death)		a consequence of						
	Examiner		Sequentially list conditions.	b. ————							
	р # <u>;</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of	7):					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of	N.	•				
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68760,	ate b	dica		d							
	Έ Ο α	Physician/Medicai	IF FEMALE:	23c. If yes, outcome	of pregnancy					22151	
Box	eath cer attendin I for use	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pregnand 5 ☐ Other (specify)	гу			23d. Date of de Month	Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown	9□Unknown	tilline or death	3 Other (specify)					
Δ.	that the de led by the a detached f	유	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying cause g	ven in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
ds,	uires tha signed d be de	d by						1 🗆	Yes 2	□No 3□P	robably 4 ⊠Unknown
Ö	w requir been si should	ete						240 1460		24h Wara a	utenay findings gyalahla
Records,	S C	Completed							opsy formed?	prior to death?	utopsy findings available completion of cause of
Vital	ysician: The lis certificate hadirector, page	Ö	25. Was case referred to medical				26. Place of Dea	1 Yes		1 Tes	S 2L NO
>	Physician: r this certifica ral director,	0	examiner? 1 □ Yes 2 🔀 No	Hospital: 1 Inpatie	ent 2 ER/Out	patient 3 DOA O				6 Nother (Spe	ocify) Daughter
of	윤 등 등	I	27. Manner of Death	28a. Date of Inju (Month, Da		me of 28c. Inju	XV	28d. Describe			Residence
lon	Attending I r death. sctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigat		y rear) in		ork?]Yes 2 ☐ No				
Division	Attendi r death. sctor: A sy the fu	ific	3 ☐ Suicide 6 ☐ Could not	d 286. Place of in	ury - At home, far	m, street, factory, office					ural Route Number,
Ö	al or A s after Il Direction by	Certification;	4 Homicide determine	building, et	c. (Specify)			City or To	own, State	9)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the		29a. Certifier 1 XCertifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge,	death occurred at the t	ime, date and place	, and due to the	cause(s) and manner a	s stated.
	the H in 24 the F iplete	Medical	one)	and manner st	ated.						
	With To T	2	29b. Signature and title of certifier			29c. Licen				ite signed (Mon	
,	20		MA			D13	2459		Αt	igust 18	2005
1	2011		30. Name and address of person wh	completed cause of							
-	1		Dr. Jim	22.2	1 01		voir Road	l, Washi	ingto	on, DC	
		ate	31. Date filed (Month, Day, Year)	32. Pegisti	rar's Signature	fraute)					
	Regist	al	AUG 2 3	LUUJ REGIST	God St	AND THE PARTY OF					

			1 - For State Registrar	State of Mary			of He				0000	27573
	Physici	an	Decedent's Name (First, Middle, Last,						2. Date of D Month	D	ay Year	3. Time of Death
	/Medic	cal	Ronald Michael Sn						08	18	2005 ear	
	Examir	ier	4a. Facility Name (If not institution, give Washington Advent	-				Location of Deat Park	h	4	c. County of De	
	Funeval		5. Social Security Number 6. Sec		yrs. last birthday)	If Under		If Under 24 Hrs	8 Date of B	irth	Montgo	rthplace (State or Foreign
	Funeral Director			IM 2□F 68		Months	Days	Hours Min.	8. Date of B (Month, D	5-19	36 Per	nnsylvania
	yland yland		10a. State 10b. County	100	c. City, Town or Lo	cation						10d. Inside City Limits
	Man.	ţō	MD Montgo	mery	Silver	Sprin	g					1 TYes 2 □ No
	be filed within 72 hours after death with the Maryland stal Hygiene. dother than "naturel", or items 23a or 28a-f show event, the Medical Examinational be notified at	al Director	10e. Street and Number 11349 Columbia Pi	ke A-2		10f. Zip		20904			itizen of What C	country?
	ems Sermin	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decede	ent of His	spanic Origin? (S	pecify Yes or N	0-	14. Race - Am	
36	or It	y Fu	1 Never Married 2 Married	1 □ Yes 2 □ No		1		Specify:	o Alcan, etc.)		Black, Wh	white
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:								
-5	"nat	lete	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usua kind of won DO NOT us	k done di	iring most of wo	rking	16b.	Kind of Busines:	s/Industry
21215-0036	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Car	,				Auto	
b	Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	ne (First, Middl	e, Maide	n Surname)	
<u>a</u>	should be and Mental s marked o umatic eve	To B	Elmer George Snyd	er				Gertru	ide Viol	la B	eatle	
Maryland	C1 10 - B		19a. Informant's Name/Relationship (Ty	рө, Print)				nd Number or Ri				
	is 1 and 2 of Health item 27 other tra		Rosa Snyder/wife							ver	Spring	MD 20904
Baltimore,	ges 1 t of H if ite or oth		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ P	emoval from State	Ob. Place of Dispo cemetery, crei	sition (Nam natory or ot	e of her place	,	Date	20c. l	Location - City o	r Town, State
#im	t. Pa rtmen rtant:		`4 □Donation 5 □ Other (Specify)		Sterling		-	,	25-2005		Sterling	g VA
Bal	permit. Pages Dep riment of t Important: If ite any injury or of		21. Signature gr Fungrat Sarvice Licens	ram	9	33 Gi	st A	of Facility al & Cre ve Silve	er Sprin	12 M	vice D 20910	
II.			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the	death. Do not ent	er the mode	of dying	, such as cardia	or respiratory	arrest,		Approximate Interval Between
	Frysician		Immediate Cause (Final disease or condition	ASPI	RATION	1 1	PNZ	UMON	IA			Onset and Death
	/Medical Examiner		resulting in death)	Due to Mr as a con	nsequence of):	2.5			,			1 77007
		- O	Sequentially list conditions,	Due to (cras a cor	MENTIF				_			1 YEAR
	uted d ansit	Examiner	flany, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·								
o,	an an rial-tr		resulting in death) Last	Due to (or as a cor	nsequence of):							
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal		l								
9	n certifica anding pl use as t	Physician/Medic	IF FEMALE:							- 1		
Вох	attenc for us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pro	Fetal death 3	Ectopic pre					23d. Date of de Month	Day Year
	res that the de signed by the a be detached	yslc	1 Yes 2 No	4∐ Pregnant at time 9□ Unknown	of death 5	Other (spe	ecify)					5 dy 1 5 d
P.0	that the		Part II. Other significant conditions cor	tributing to death but no	t resulting in the u	nderlying ca	use giver	n in Part I.	23e. Did	tobacco	use contribute t	to the cause of death?
of Vital Records,	quires n sigr ald be	d by							1 🗆	Yes 2	200 3□P	robabiy 4 Unknown
000	aw requir as been si 2 should	oleted							24a. Wa	s an	24b. Were a	utopsy findings available
æ	The la ate ha page 2	ldmo								ormed?	prior to death?	completion of cause of
ital	ien: rrtifica ctor, p	BeC	25. Was case referred to medical					26. Place of Dea	th (Check only	2□N one)	0 10 10	s 2,60 No
) (Physicien; this certificaral director, I	ToE	examiner? 1 ☐ Yes 2X No	ospital: 1XX Inpatient	2 ER/Outpatier	t 3 DO		4 Nursing H			6 ☐Other (Spe	ecify)
o uoi	ding h. After fune		27. Manner of Death 1 ✓ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28 M	lc. Injury a Work?	at ? es 2 □ No	28d. Describe			
Division	or At ifter of Direction by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Sp	At home, farm, str	eet, factory,	office	-	28f. Location City or To	(Street a	nd Number or A	lural Route Number,
	To the Hospitel or Ai within 24 hours after or To the Funerel Directompletely filled in by	dical Ce	29a. Certifier (Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exam	knowledge, death	occurred a	t the time	o, date and place	, and due to the	cause(s	s) and manner a	s stated.
	To the P within 24 To the F complete	Medi	5710)	and manner stated.	milation and or in				ired at the thine			
	Viti	~	29b. Signature and title of certifier Mulsonflue	Ma DHU	SICIA		License -		9	29d. Da	ate signed (Mon	th, Day, Year)
,	1											0, 2000
1	MI		30. Name and address of person who co				RTH	PUTOM.	10, 1	1D.	20878	
:	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3 2005	32. Registrar's S	ignature doe	de la						

				For State Registrar	State of Maryla		partment of I			giene Reg. N2 0 0 5	27571
			tie y .	Decedent's Name (First, Middle,			0 10 1	711	2. Date of De		3. Time of Death
		Physicia /Medic	al	YVONNE	TURNE	R	S////	or Location of Deat	AUGUS		
		Examin	er	4a. Facility Name (If not institution, 9010 ISRIAR	CROFT W.	# 420	LAC	REL	11	PRINCE	CEORGES
	E-sp	Funeral	-	5. Social Security Number 6		s. last birthda	Months Davs		(Month, Da	th 9. Birth	nplace (State or Foreign untry)
		Director		216-36-7370 Usual Residence of Decedent	61	Yrs.			may 2	4,1938 MAI	RYLAND
	Spel	show show		10a. State 10b. County		City, Town or					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	a M	or 28a-f s	ecto		E GEORGES	LAC	DREL			10g. Citizen of What Co	•
	brew Mary the Maryland	Se or 2	Dir	10e. Street and Number 9010 BRIARCA	ROFT IN API	#42	10f. Zip Code	708		1) S. A	unity:
	t e a c	orealms 2:	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origin? (S	Specify Yes or No to Rican, etc.)	14. Race - Ame Black, White	
	36	, or ite	y Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced			1□ Yes 2⊠ No		,	Specify:	LACK
-	5-003	n 72 nours arier dearn with the maryer "naturel", or items 23e or 28e-f shov cical Examiner must be muffled at	Completed by Funeral Director	15. Decedent's	s Education	16a. De	cedent's Usual Occu	pation	rking	16b. Kind of Business/	
31	T .		nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life	e. DO NOT use retire	ed)	_	DEPORTME	UT OF ARCHIVES
V)	d 21	Hygier Hygier Sther ti	e Col	17. Father's Name (First, Middle, L	2 YEARS	1-1	HOTOG			, Maiden Surname)	
23	lan	should be filed withing to Mental Hygiene. marked other than matic event. It e M.	To Be	RODELL		RNEI	R SR.	BEAT	RICE	Wa	DARD
3	Maryland	s 1 and 2 should be filed with f Health and Mental Hygiene. item 27 is marked other than other traumatic event, I.e.M		19a. Informant's Name/Relationshi						er, City or Town, State, Z	
ONN	e, 1	1 and Health em 27		ODELL SM1		. Place of Di	sposition (Name of	!	Date Date	WINGS MILL 20c. Location - City or	
0	altimore,	ages ent of nt: If it ry or o		1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 □Removal from State	cemetery, c H.CALV	Crematory or other place.	1em. 08-0	23-2006	ARNOLD,	MARYLAND
Ž	Baltii	permit. Pages 1 and 2 should be litted with Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, Item <u>once.</u>		21. Signature of Funeral Service L		me	22. Name and Addr	ess of Facility M. BROL	IN JA	R. FUNERAL IMORE, MI	HOME
				23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that caused the d						Approximate Interval Between
	P	hysician		Immediate Cause (Final disease or condition	Lymo	hor	ma				Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a dons	equence of):					
			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a cons	sequence of):					
		executed in and ial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с						
	8760,	rate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):					
	0	certificate be nding physicia use as the bur	edic		d						
	Вох	leath certifica attending ph	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death	3 ☐Ectopic pregnan	су		23d. Date of del Month	ivery Day Year
	0.	he dea the al	ysici	1 Yes 2 No 9 Unknown	4□Pregnant at time of 9□Unknown	of death	5 ☐ Other (specify)				
	ls, P.O	The law requires that the death ste has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant condition	ns contributing to death but not	resulting in th	e underlying cause g	iven in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pr	the cause of death?
	ord	v requi	Completed						24a. Was		
	Rec	The tav ate has page 2	dwo				-		auto	psy prior to death? 2. No 1 Yes	itopsy findings available completion of cause of 2 No
			Be C	25. Was case referred to medical examiner?					ath (Check only		2010
	of V	Physic this ce al dire	2	1 ☐ Yes 2 1 No	Hospital: 1 Inpatient 2		Ment 3 DOA			idence 6 Other (Spe	cify)
	on	tending Physician: leath. tor: After this certific the funeral director,	tion	1 Natural 5 Pending 2 Accident investig) Inju	ry W	ork? □Yes 2□No	200. 20001120	new injury occurred	
	Division of Vital Records,	or Attendii Iter death. Iirector: A n by the fu	Certification;	3 Suicide 6 Could n 4 Homicide determi	28e. Place of Injury - A building, etc. (Sp.	t home, farm	, street, factory, office	9	28f. Location City or To	(Street and Number or Ruwn, State)	ıral Route Number,
		To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and an additional process.	edical Ce	29a. Certifier 1 🛣 Certifying	g Physician: To the best of my Examiner: On the basis of exam	knowledge, d	eath occurred at the	time, date and plac	e, and due to the	cause(s) and manner as	stated.
		thin 24 thin 24 the 5 mplete	Med	one) 29b. Signature and title of certifier	and manner stated.			nse number		29d. Date signed (Mont	
		+ ≥ ∓ 8 ≺		Mahuk	Challin	an	Da	∞	50	8/19/	05
	1	0			who completed cause of death (pe, Print)			, LARGO, MI	20324
	1			MAHRUKH 31. Date filed (Month, Day, Year)	HUSSAIN, 10		221 111	EKCANTI	LE LANE	, CHKGO, MID	00114
		St: Regist	ate rar	AUG 2			Coule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1310 Norma Smith Au 6451 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea April 11, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Year) 1 ☐ M 2 🕱 F 79 Yrs. 1926 Maryland 216-20-7723 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f shown my injury or other traumatic event, the Medical Eranit or must be rediffed an once. Maryland Harford Joppa 1 Yes 2 XNo Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Fitzhugh Road U.S.A. 21085 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union Office Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hissey Bortner Arthur Theoda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Albert E. Smith, Jr. - Son 203 Fitzhugh Road Joppa, MD 21085 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Gardens of Faith 8/23/05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a una uence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner the attending physician and the for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2- No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b Were autopsy findings available prior to completion of cause of death? 24a Wasan me 2 No 1 Yes 1 Yes 25. Was case referred to medical Ejection traction or Attending Physicien: Be 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes _ 2 No 1 Inpatient 2 ☐ ER/Outpatient _ 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 14 Natural 5 Pending death. 1 🗌 Yes 2 🗌 No investigation 2 Accident completely filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

DORMA

ME#MBGUJ 5870I

State Registrar 31. Date filed (Month, Day, Year)

AUG 23

2005

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who com

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

cause of death (Item 23a) (Type, Print)

32. Reginature

	1. [Decedent's Name	(First, Middl	e, Last)						e of L			2. Date of I	eath	<u> </u>	3. Time o
ician dical		Mar	у	D'Ad	amo	Snyc	ler						Month August	0.	ay Yea L 2005	_
iner	4a.	Facility Name (If r	ot institution	n, give stre	et and nur	nber)			4b. City,	Town, or	Location of	of Death		4	c. County of D	eath
		3556 Ca		-				4 6 5 4 5 4 1 1			if Under		0.000		Baltime	
	5. 3	Social Security Nur 212 – 20–3	588	6. Sex 1 ☐ M	2 🛣 F	7. Age (In 93	yrs. iasi	r <i>birtnd</i> ay) Yrs.	Months		Hours	Min.	8. Date of E (Month, I	Day, Yea		Birthplace (State Country)
	Us	ual Residence of D	ecedent										June 0	0, 1	912 Ma	aryland
_		a. State MD	10b. County			100		Town or Lo								10d. Inside C
Funeral Director				imore			ка	ndal.	Lstown					T		1 🗆 Yes
5	106	e. Street and Numb		11.11	1 0:	•	m o		10f. Zip						itizen of What	
	11.	3556 Ca	rriage		Was Dece	edent Ever		13.		133 dent of Hi	spanic Ori	gin? (Sp	ecify Yes or I			ates Of merican Indian,
		1 Never Married	d 2 ☐ Mar		Amed Fo 1 ☐ Yes	rces? 2 ☑ No				7.7		i, Puerto	Rican, etc.)			/hite, etc.
	•	3 XWidowed 4	Divorced	i l	If Yes, Giv Year or D	rates:			1 □ Yes		Specify:				Specificat	ucasian
1		(Specify	5. Deceder only highe	nt's Educati est grade co	ion o <i>mpleted)</i>		•	16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	ation Juring mos	t of work	ting	16b.	Kind of Busine	ess/Industry
		Elementary/Second	dary (0-12)		College (1	1-4or 5+)								Y 1		77.1
		Father's Name (F	irst, Middle,	Last)	4		I	sene	001 Te	eacne		er's Nam	e (First, Midd			y Educat
lo Be		Peter	D''Adaı	mo							Ca	rme1	а та	ovet	-to	
_	19	a. Informant's Nan						19b. Maili	ng Address	s (Street a					or Town, State	e, Zip Code)
		Mr. John	Paul	Snyd	er	(Son						ourt	, Crof	ton,	Mary1a	and 2111
	20:	a. Method of Dispo 1 □XBurial 2 □		3 □Rem	noval from	State 20	0b. Plac cem	ce of Dispo netery, crea	osition (Nar matory or o	me of other place	9)		Date	20c.	Location - City	or Town, State
		`4 □Donation 5				D	rui									e, Maryl
	21	. Signature of Fund	eral Service	Licensee				21	2. Name an	nd Addres	s of Facilit	^{by} Lor	ing By	ers	Funeral	l Direct
			10 4	/				19.4								4 4 6
	lm	Ba. P.m. Enter the shick, or heart mediate Cause (F sease or condition sulting in death)	dis ase, o failure. List	r complicat	tions that o	ach line.	death.	Do not en	728 Li	ibert	g, such as			1sto	wn, Mai	Approxima Interval Be Onset and
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	Examir	er	4a. Facility Name (If not institution, give si 2412 PLAINFIELD RO 5. Social Security Number 6. Sex		last hirthday)	DU	, Town, or JNDAL or 1 Year	Location of Dea K If Under 24 Hr		В	ALTIMORE	CO place (State or Foreign
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980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exa-ciding roual be notified at ADGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Pes	cify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.))-	14. Race - Americ Black, White, Specify: Whi	etc.
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8760, ~	sate be executed obysicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq								
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	Ideath 3	⊒Ectopic p ⊒ Other (s	pregnancy pecify)				23d. Date of deliv Month	ery Day Year
rds, P	8 5 9	þ	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	ınderlying	cause give	en in Part I.		obacco Yes 2	1	he cause of dealh? bably 4 □Unknown
Vital Records,		Completed							24a. Was auto perfo 1 🔀 Yes	psy ormed?	prior to co death?	opsy findings available impletion of cause of
Vita	Physician: Th this certificete al director, pag	Be	25. Was case referred to medical examiner? 1XX es 2 \sum No	ospital:	anio .		Othe		eath Check only			CCENE
of	Jing After fune	ation: To	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	4 Nuising	28d. Describe		6 XIX ther (Special ry occurred	y) SCENE
Division	i Diff o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st	reet, facto	ry, office		28f. Location (City or To		nd Number or Run e)	al Route Number,
	e Hospital 124 hours a Funeral I letely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knower: On the basis of examina and manner stated.	wledge, deat ition and/or in	th occurred evestigation	d at the tim n, in my of	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s date and) and manner as s d place, and due t	stated. o the cause(s)
	To the within 2 To the complete	Ň	29b. Signature and title of certifier	eef nu)	25	O C	number M E			ite signed (Month, GUST 20,	* * * * * * * * * * * * * * * * * * * *
	10		30. Name and address of person who could be seen and address of person address of person and address of person addre	1 - 1	п 23а) (Туре,	Print)	PENN	STREET	, BALTIM	ORE,	MARYLAN	D, 21201
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 3 2005	32. Registrar's Signa	iture							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** TNNA 2:19 8 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BALTIMORE BAYVIEW BALTIMORS
Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 M 2 F NOV 2, 1917 Director 87 PA 181.01.6676 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE DUNDALK MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3309 McSHANE WAY 21222 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No XX Baltimore, Maryland 21215-0036 Specify: Specify % Widowed 4 ☐ Divorced Year or Dates: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe Pages 1 end 2 should be ment of Heelth and Menta tant: it item 27 is marked CATHERINE BGCHECHKI BORIS HARRY BORIS 2 treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON P.O. BOX 699 SPOTSYLVANIA, VA 22553 JOHN SMITH other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō permit. Page Depertment important: if any injury or JOSEPH'S CEM BUTLER TWP., PA 8.23.2005 of uneral Service Licens 21. Sign FINE FUNERAL FHOME, P.A. GREGORY 426 CRAIN HWY SW GLEN BURNIE, MD 21061 MO1148 Approximate Interval Between Onset and Death Enter the disease, or compli-c or heart failure. List only or tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Seuse (Final disease or condition resulting in death) Pnysician day PERFORATED CELUM /Medical Due to (or as a consequence of) Examiner OLON CANCEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 Other (specify) 4 Pregnant at time of death s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★No 24a. Was an autopsy 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Munpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 KNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ector: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide atter To the Hospitel o within 24 hours att To the Funerel Di completely tilled in 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS BAYVIEW, 4940 EASTERN AVENUE, BACTIMORE, MD 21224 DEBASHISH BOSE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - State Registrar		artment of He		Re	9. N2 0 0 5	27580
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) ARDEN 4a. Facility Name (If not institution, give street and number) Howard County General Hospit	CHATZ	4b. City, Town, or L	ocation of Death	2. Date of Death Month O	Day Year 19 2065 4c. County of Dea	alh
	Funeral Director		*	In yrs. last birthday, 75 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth Dec. 10,	Howa (1929 M	rd httplace (State or Foreign lountry) aryland
	e Maryland 3e-f show diffed at	ctor	Maryland Howard	oc. City, Town or L Elkridg					10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	th with the	Funeral Director	10e. Street and Number 6252 Old Washington Rd.		10f. Zip Code 21075		10	Og. Citizen of What C	ountry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Ifem 27 is marked other than "neture!", or Items 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at	ρχ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ar in U.S. 13.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ▼ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
21215-0036	filed within 72 ho Hygiene. other than "netur ent, I're Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occupat e kind of work done du DO NOT use retired) Pervisor	ion uring most of work	ing	Soci	s/Industry al Security
and 2	d be filed ental Hyg ced other c event,	To Be C	17. Father's Name (First, Middle, Last) James Leo Schatz			18. Mother's Name	et A. Ba	faiden Sumame)	ar becarry
Maryland	d 2 should be the and Mental H T is marked of traumatic eve	ř	19a. Informant's Name/Relationship (Type, Print) Kenneth Gronberg, cousin		ing Address (Street ar 2 Beechfie	nd Number or Rura	Il Route Number,	City or Town, State,	Zip Code)
Baltimore,	00		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	•	osition (Name of ematory or other place, dge Memori)		20c. Location - City of	
Balti	permit. Pag Department importent: i any injury o once.		21. Signature of Funeral Service Licensee	2	2. Name and Address Ambrose Fu 1328 Sulph	of Facility neral Ho	me, Inc.		
8760,	In price personned the price p	lical Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). Due to (or as a condition of the cause). Due to (or as a condition of the cause). Due to (or as a condition of the cause). Due to (or as a condition of the cause).	consequence of):	HOCK irabilis			St,	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
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Division of Vita	r Attending Physicien: The ter death. Irector: After this certificate iby the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	(ear) 28b. Time of Injury	of 28c. Injury a Work? M 1 \(\text{Ye}	es 2 No	me 5 Resider 28d. Describe ho	nce 6 Other (Spewinjury occurred	
Ō	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical Cer	29a. Certifier 1 Cartifying Physician: To the best of response one) 2 Madical Examiner: On the basis of examiner and manner stated	my knowledge, dea kamination and/or in	th occurred at the time	e, date and place, anion, death occurr	and due to the ca	use(s) and manner a	s stated. e to the cause(s)
)	To th within To th comp	Σ	29b. Signature and title of certifier Chalac Berzingi	, MA	29c. License	a= / a ¥	2/	8 11910	
	10		30. Name and address of person who completed cause of deat Chala Bevzing: 31. Date filed (Month, Day, Year) AUG 2 3 2005	h (Item 23a) (Type	Print)	kway si	iit Ros	Greenb	elt Mp 2077
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) 32. Registrar's AUG 2 3 2005	Signature	Sperter	V			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:55 P.M Norma Irene Eva Siegmann August 21, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Genesis ElderCare Severna Park Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Yrs. Director 87 214-14-9565 Maryland Aug. 16, Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show rei', or items 23e or 28e-f shore Examiner outilised at 1 ☐ Yes 21 No Directo Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Truckhouse Road 21146 USA filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 X Widowed 4 ☐ Divorced ar or Dates "neturel', the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "ns any injury or other treumatic evant, The Media 2006. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milbert McKitrick May Caroline Limbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4780 F Water Park Drive: Belcamp, Maryland 21017 Charles Siegmann Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 8/23/2005 Beltsville, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fusion Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** vance disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events iding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 You 3 Ectopic pregnancy signed by the atter Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 🗌 Yes 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pendina death. M 1 Tes 2 No investigation 2 Accident after death 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel I (S) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nger 8601 Veterans Hwy denniter 10 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			Decedent's Name (First, Middle, Last)			unodio oi E	Journ	2. Date of Death	Nó. UUU	3. Time of Death
	Physici		RICHARD CONEY STOV	ER				Month August	20, 2005	9:55 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and nur			4b. City, Town, or	Location of Dear		4c. County of Death	
ı			Oak Crest Care Center			Parkv	ille		Baltimo:	re
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last			If Under 24 Hrs Hours Min	8. Date of Birth	Q Birth	nplace (State or Foreign intry)
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	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
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	r 28a	rec	10e. Street and Number	La	TKVTI	10f. Zip Code	•	10g	. Citizen of What Cor	untry?
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	ems ems	ner		edent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-	14. Race - Amer	
36	within 72 hours after death with the Maryland one. then "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 Never Married 1 Never Married 2 Never Married 1 N	2 🗆 No		Yes 2 X No		to rican, etc.)	Black, White	
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77	with jiene.	Completed	Elementary/Secondary (0-12) College (1 12 years	-4or 5+)		xtermina			Pest Cont	rol
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Maryland	should be filed vand Mental Hygies smarked other toumetic evant, In	ToE	Charles Edgar Coney				Adeline	. Virgin	ia Coney	
lan	2 sho and I Is me		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or R	ural Route Number, C	City or Town, State, Z	^(p Code) 21234
	and ealth m 27 har tr		Beatrice Stover (wit		8810	Walther 1	Blvd. A			, Maryland
OLE	ges 1 t of H If ita or ot	- 3	20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □ Removal from	State 20b. Place	e of Dispo: etery, cren	sition (Name of atory or other place)	Date 20	c. Location - City or T	own, State
Baltimore,	t. Pa rtmen rtant: rjury		`4 □Donation 5 □ Other (Specify)	Gree		nt Cremat		23-05 Ba	altimore,	Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, if a Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	-	Mi	tchell-Wi 500 York	Ledefeld Road F	Funeral Baltimore,	Home, Inc.	21 21 2
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. [Do not ente	r the mode of dying	, such as cardia	c or respiratory arrest	,	Approximate Interval Between
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		_	Sequentially list conditions, if any, leading to immediate b. Due to	or as a consequen	on of):					
7	uted Insit	nin	cause. Enter Underlying Cause (Disease or injury	o. 25 a consequent	00 01).					
<i>'</i>	execuna and ial-tra	Examiner	that initiated events resulting in death) Last	or as a consequen	ce of):					
58760,	ficate be executed physician and s the burial-transit	dlcal	d							
_	ntifica ng ph		IF FEMALE:			_				
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant 23c. If yes, out	come of pregnancy inth 2 Petal de	ath 3	Ectopic pregnancy			23d. Date of delin	•
	es that the death certific igned by the attending p be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregn 9 ☐ Unknown 9 ☐ Unknown	ant at time of death	n 5⊡	Other (specify)			MONUT	Day Year
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ecc	has be	Completed						24a. Was an autopsy		opsy findings available ompletion of cause of
<u> </u>		Соп						performe 1 Yes 2 ₩	d2 death?	
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Division of	Attending Physician: r death. actor: After this certifica by the funeral director.	lon	J Siding	th, Day Year)	b. Time of Injury	28c. injury Work		28d. Describe how	injury occurred	
<u>S</u>	or Attending I after death. Diractor: After in by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e Place	of Injury - At home	farm stre		es 2 No	28f Location (Street	et and Number or Rur	al Pauta Number
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			amonia	7		055	5646	1 6	Pogost 2:	2, 2005
	13		30. Name and address of person who completed caus		а) (Туре, і	Print)	N 1) -	1	2, 2005
	Sta	te		SSOO egistrar's Signature	Wa	ther	Isoule	Jako Po	skrille, V	4 21234
ð	Registr		AUG 2 3 2005)	Median.	A.	Goodes				

State Registrar Pay. Year) / 2 3 2005

2. Registrar's Signature

8-20-05

				For State Registrar			Marylan	-	artment o				Reg. No	005	27585
		Physicia /Medic	_	Decedent's Name (Fire Ragner Toug.		st)						2. Date of De Month	Day	Year 2005	3. Time of Death
		Examin		4a. Facility Name (If not i						n, or Location				ounty of Death	
				5. Social Security Number		an Hosp		last birthday)	Bat If Under 1 Ye	timore	e or 24 Hrs.	O Data of Bi		/A	place (State of Femilia
		Funeral Director		106-24-5195	0. 3	Sex 7.	85	Yrs.	Months Da			8. Date of Bi (Month, D. June 17	1920	Rus	place (State or Foreign intry) \$13
1	7	9		Usual Residence of Dece								CONT.	, 1320	1100	J14
	book and the Manual	a-fehow	ctor		. County /A			altimore							10d. Inside City Limits 1 X Yes 2 □ No
	th th	or 28	Olre	10e. Street and Number					10f. Zip Cod				10g. Citize	on of What Cou	intry?
	7	238	Ta I	1103 Sherwoo	d Avenue				212					USA	
900	5-UU36	perint. Tages I and a should be first writing to house after death with the wayran perint of Health and Mental Hydines. Important: if them 27 is marked other than "natural; or itams 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 1		12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? No		Was Decedent If Yes, specify (1 ☐ Yes 2 ☐ X			ecify Yes or No Rican, etc.)		I. Race - Ameri Black, White pecify: White	, etc.
L	ה ה ה	natu	Completed		Decedent's E	ducation ade completed)		(Give	dent's Usual Oo kind of work do	ne during mo	ost of work	ing	16b. Kind	of Business/Ir	ndustry
~ *	Z 4	Doe.	Id I	Elementary/Secondary	(0-12)	College (1-4	or 5+)		ng Clerk	,				hipping	
2	170	Hygie ther ant, II	ပိ	17. Father's Name (First,	Middle, Last)		Silibb	ing clerk		her's Nam	e (First, Middle		hipping umame)	
ougjas	Maryland	d Mental narked o	To Be	Otto Tougjas				1 105 11-11		Add	olphin	e Kokk			0.11
10	Ma	traur		Holla Tougjas		Type, Print)			ing Address <i>(Sti</i> Sherwood			imore Mar			p Code)
	ව දි	Heal tem 2		20a. Method of Disposition			20b. F		osition (Name o matory or other			Date	-	ation - City or T	own, State
	Saitimore,	ages ant of nt: if i		1 ☐ Burial 2 🂢 Cre 4 ☐ Donation 5 ☐	mation 3 [Removal from St			ervice Co		8/23	/05	Towson	Maryland	1
		oortar injur	1	21. Signature of Funeral			na L. H	ilton 2	2. Name and A	dress of Fac			10115011	i wi y i wi k	<u> </u>
Ċ	n a	Depa Impo		Mis	tua	L. He	lto	~!	2. Name and Ad Leonard J 5305 Harf	. Kuck, ord Road	inc. 1 Bal	timore Ma	arvland	21214	
		hysician and managed as a the private and to a set the private transit to a set the private transit to a set the private transit to a set the private transit	al Examiner	shock, or heart failt Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(a. Carc Due to (or b. Cong Due to ()	clioge as a conseq	quence of):	shock cart Fa	úlure ion	<u> </u>				Interval Between Onset and Death
9	0 4	physi the t	de			_ d									
2	ם إ	y the attending	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown			h 2∏Feta ntattime of d	I death 3	□Ectopic pregna □ Other (specify				23	d. Date of deliv Month	ery Day Year
	Records, P.O.	been signed by the a should be detached t	Completed by PI	Pulmonary		contributing to dea	th but not res	sulting in the u	anderlying cause	given in Part	t I.			contribute to t	the cause of death?
ner		0 70	plet	Corporry A	rteru	Disease	<u>.</u>					24a. Was		24b. Were auto	opsy findings available
6	¥ 4	ste has	E		brillai							auto perfe 1 \(\text{Yes}	ormed?	death?	empletion of cause of
Rag	VITA	ortifice ctor, i	Bec	25. Was case referred to examiner?		iuv	vs 84_5			26. Plac	ce of Deat	h (Check only			
W ?	OT VITA	his ce	ဥ	1 ☐ Yes 2 ☑ No		Hospital: 1 🗹 Ing		ER/Outpatie	nt 3 DOA		lursing Ho	ome 5 🗆 Res	idence 6	□Other (Speci	fy)
	DIVISION O		Certification:	2 Accident	Pending investigatio	n	Injury Day Year)	28b. Time o Injury	of 28c. I	njury at Work? 1 ∐ Yes 2 €	No	28d. Describe	how injury	occurred	
č	5 8	s after do	Certific	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of	f Injury - At h , etc. <i>(Specif</i>	ome, farm, st fy)	reet, factory, off	ICe		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
	J istinged att	24 hour	edical	29a. Certifier 1 (Check only one)	Certifying Pl Medical Exa	nysician: To the b miner: On the bas and manne	is of examina	owledge, deat ation and/or in	th occurred at the	e time, date a ny opinion, de	and place, eath occur	and due to the red at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. to the cause(s)
	-	To the comp	ž	29b. Signature and title of	of certifier	7.			29c. Lic	ense number			,	signed (Month,	
				mil 1	9 4	romg	,m	D	RZ	=5-0	000		08/2	1/200	5
_	3	7		30. Name an address o	f person who	completed cause	of death (Item	п 23а) (Туре,	Print) Jin	g Jiane	3				
	C	Acres de la constitución de la c		5601 Loch 31. Date filed (Month, Da	Roven	Boulev	ard.	Baltir	nure, or	arylan	di	21239			
		Sta Registr				2005	ystrar's Signa		Lack .						

			For State Registrar	State o	f Maryla		artment of F		Mental Hygi	iene g. N2 0	05	27586
	Physicia		1. Decedent's Name (First, Middle, La	Thor	00				2. Date of Death Month	Day	S ^{Year}	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give A+1an+c Gen	e street and nu		tal	4b. City, Town, o	r Location of Dea		4c. Coun	ty of Death	
	. Funeral Director		5. Social Security Number 6. S			s. last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		^Y 1915	Coul	place (State or Foreign ntry) ginia
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Worceste:	r		City, Town or I						10d. Inside City Limits 1 Yes 2 □ No
	s or 28a-	Direc	10e. Street and Number 306 Oyster Lan				10f. Zip Code 21	842	10	Og. Citizen o	f What Cou	ntry? A .
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "neturet', or Items 23s or 28a-f show any injury or other traumatic event, the Medical Evantical metal to middle and ODGe.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	² X ^{No}	U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes XX No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	В	ace - Ameri ack, White, hify: White	etc.
Baltimore, Maryland 21215-0036	within 72 hou ene. then "neture	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade completed) College ((Giv	edent's Usual Occup to kind of work done DO NOT use retire ice Clerk	during most of wo d)	orking	Nave	Business/In	
/land 2	uld be filed Mental Hygi irked other itic event, I	To Be C	17. Father's Name (First, Middle, Last Sylvester J. Ho						ame (First, Middle, M e May Part		ame)	
Mary	nd 2 sho lith and / 27 is ma r traums		19a. Informant's Name/Relationship Arlene Jenkins		er)				Rural Route Number, cean City			
ore,	ages 1 au nt of Hea : If item		20a. Method of Disposition 1 🗓 Burial 2 🗆 Cremation 3		State	cemetery, ci	position (Name of ematory or other pla		. 25,	20c. Location		own, State aryland
Baltin	permit. Pa Departmer Important any injury once.		4 □ Donation 5 □ Other (Special Signature Fundfal Vide Line)	7	10/5			ess of Facility	005 Lee Funera ia Ferry I	al Hom	e. I	nc n _: MD20735
	Physician		23a. Parí 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on	each line.		nter the mode of dyi			est,	3	Approximate Interval Between Onset and Death
095	/Medical Examiner			b	(or as a cons							
0	cate be executed physicien and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a cons							
1,2005 68760,	tificate being physicias the bu	edicai	•	d								
10 XNE 3 100 8/3/ 10. Box	ndir use	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 9 Unknown		birth 2□F nant at time o	etal death	B □Ectopic pregnanc i □ Other (specify) _	ey .			Date of deliv Month	r ery Day Year
ds	requires that the een signed by th nould be detache	d by Ph	Part II. Other significant conditions NUDEC #1510	-	death but not	resulting in the	underlying cause gr	ven in Part I.		oacco use co		the cause of death?
1/1915 Recor	e law has b je 2 sl	omplete	diabetes M	ellitus	3				24a. Was a autops perforr	y	o. Were autoprior to condeath?	opsy findings available ompletion of cause of
12/2/ital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						eath (Check only on	9)		
ANN Das on of V	Physic r this co	2	1 Yes 2 27. Manner of Death	28a. Date	of Injury	2 ER/Outpat	of 28c. Inju	iry at	Home 5 Reside			ify)
A D	Attending Physicien: or death. ector: After this certific by the funeral director,	ation	1 ☐ Actural 5 ☐ Pending 2 ☐ Accident investigati	on (Mo.	nth, Day Year	r) Injur	/ Wo	ork?]Yes 2□No				
ا الم ال Division	or Dir	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 288. Plac	e of Injury - A ding, etc. (Sp	t home, farm, ecify)	street, factory, office		28f. Location (Si City or Town	treet and Nui n, State)	mber or Rur	ral Route Number,
	spite nours nerel	edical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	aminer: On the	ne best of my basis of exam nner stated.	knowledge, de nination and/or	ath occurred at the tinvestigation, in my	ime, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)
	To the Ho within 24 h	Me	29b. Signature and title of certifier	Luga	er, n.	0	C1-	se number	95	9d. Date sig	05	
	10 1		30. Name and address of person wh	o completed car	use of death (Item 23a) (Typ	e, Print) HIGH	vary FE	NULKI	SUAN	10, 0	= 1994
	St	ate	31. Date filed (Month, Day, Year)	32	Registrar's Si	ignature						

			1 - For State Registrar	State of Maryland	l / Depa		Health and	Mental Hygi		7
86	Physici /Medio	al	Decedent's Name (First, Middle, Last) Beryl Agatha Todd As Facility Name (If not institution, give s	treet and number)		4b City Town	or Location of Dea	2. Date of Death Month August 2	Day Year 2, 2005 12:05 A	
	Examin	ier	Frederick Villa Nu	rsing Home		If Under 1 Yea	Catonsvi	11e	Baltimore	
	Funeral Director		215-28-3342 Usual Residence of Decedent	M 2 F 7. Age (In yrs. la.	Yrs.	Months Days			(ear) 9. Birthplace (State or Fi Country) British Guia	ana
	Maryland a-f show	ctor	10a. State 10b. County MD Baltin		Town or Lo	cation Arbu	ıtus		10d. Inside City L	-
	h with the	ai Director	10e. Street and Number 1241 Vogt Avenue			10f. Zip Code	21227	100	G. Citizen of What Country? United States	
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f ehow marked other than "natural", or items 23a or 28a-f ehow maric event. If a Medical Exerting the redifficial at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Zovorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	l t	Vas Decedent of f Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	ithin 72 ho nan "natur nan "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)			upation e during most of wo ed)	orking 16	Sb. Kind of Business/Industry	
12 pu	e filed wall Hygier I other th	Be Cor	12 17. Father's Name (First, Middle, Last)		-	Clerical	7	me (First, Middle, Ma	Retail	
Ŋ	thould b	To	Moresby Kirby 19a. Informant's Name/Relationship (Type	ne Print)	19h Mailin	n Address (Street			nie Donaldos City or Town, State, Zip Code)	
, Ma	and 2 sealth and n 27 la		Bobbi Tayman POA		1238	Vogt Av		tus, MD 21		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic e once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State 20b. Pla	ce of Dispo negany crem Stan emete	sition <i>(Name of</i> patory or other pl ISIAUS ry	ace) 8-2.		oc. Location - City or Town, State undalk, MD	
Zalt≡	ermit. I Separtm nporta ny Inju	(21. Son yure of Funeral Service License		22	. Name and Add	ress of Facility A	mbrose Fun	eral Home, Inc.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death.	Do not ente	328 Sulp or the mode of dy	hur Sprii ring, such as cardia	ng Rd., Ar	butus, MD 21227 t. Approximate Interval Between	
	Pnysician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	Shu	e to T	hrive		Onset and Dea	th
68/60,	ficate be executed physician and is the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
C. BOX	death cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	leath 3	Ectopic pregnan Other (specify)	су		23d. Date of delivery Month Day Year	r
rds, P	The law requires that the tee has been signed by the page 2 should be detached.	by	Part II. Dther significant conditions conf	ributing to death but not result	ting in the ur	idertying cause g	iven in Part I.		cco use contribute to the cause of death	
Vital Records,		e Completed	25. Was case referred to medical				00 Pierre of De		24b. Were autopsy findings avaired of completion of cause death? 1 Yes 2 No	lable e of
01 \	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No		R/Outpatien	t 3□ DOA O		ath Check onlone Home 5 TResidence	ce 6 Other (Specify)	
ono	Attending F death. ctor: After y the funera	ation:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury		ury at ork? □ Yes 2 □ No	28d. Describe how	injury occurred	
DIVISION	To the Hospital or Attending Physician: within 24 hours deflet death . To the Funeral Directors the contilion completely filled in by the funeral director, completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office	3	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)	
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the cau- urred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier	· M/o 1-		29c. Licer	nse number	29d	. Date signed (Month, Day, Year)	
	h		30. Name and address of person who	pleted cause of death (Item 2	ype, I	Print)	>0707	- 2	8 12215 Odollo E. Fernan	مصرکم
			405 Fledonick 31. Date filed (Month, Day, Year)	Vd Stell6	70 0	Cath	mlle 2	1228-	M	08
le.	Sta Registr		NIC o 2 200	89.	400	and it				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 U 0 5 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Betty Hatley Tecco /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita TOOKE If Under 24 Hrs. 5. Social Security, Number Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 1 F 240-28-9455 Yrs 82 Director 10-09-1922 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2X No Director Maryland Baltimore Catonsville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 609 Oak Hill Road 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Clerk Government s 1 and 2 should be filed if Health and Mental Hygic Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Hatley 2 Rebecca Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edison W. Tecco, Sr. - Husband 609 Oak Hill Road Catonsville, MD 21228 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If Ite eny Injury or ot Crestlawn Memorial Gardens 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 08-20-2005 Marriottsville, MD 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave Catonsville, MD 21228 21. Signature : Funeral Service License Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death A COLUMNIA DE MODICAL ENDINALES Immediate Cause (Final disease or condition resulting in death) Subden **Physician** hows /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit Exam Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 9 🗆 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗷 No 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy lindings available prior to completion of cause of death? has autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 🖪 No Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natoral 5 Pending 5 hekwinds August 16,2005 1:00 PM 1 ☐ Yes 2 ☑No death. investigation 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital o within 24 hours aft To the Funeret Di nome oukhill Roack 609 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 238543

Registrar

DHMH 17 Rev 1/2001

State

ORIGINAL

900 Cater frame Baltimore, Many land

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

14. Similages nul

3 2005

31. Date filed (Month, Day, Year)

		1	For State Registrar	State of Maryland / Do	epartment of H Certificate of L			ene a No 0 0 5	27589
			Decedent's Name (First, Middle, Last)				2. Date of Death	n Day Year	3. Time of Death
	Physicia	an	11 - > + 1				August	18 2005	1138 AM
	/Medic Examin		1a. Facility Name (If not institution, give str		4b. City, Town, or	Location of Death	9	4c. County of Deat	h
	Examin	Ç:	University of Man	yland Medical Cent	er Bal	timore		NA	
	Funeral Director	1	Social Security Number 6 Sex	7. Age (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 07-15-19	Year) 9. Birt Co Mary	hplace (State or Foreign untry) Land
		-	Usual Residence of Decedent						
1	Now T		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 X Yes 2 □ No
	Mar-fat	tor	MD NA	Balti	imore				
	or 28:	Director	10e. Street and Number		10f. Zip Code	_	11	0g. Citizen of What Co	untry?
	23a c	alD	5226 Cromarty Road		21229			USA	
-	ems	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
စ္က	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify: B	lack
	hours tural		3 Widowed 4 Divorced 15. Decedent's Educa		Decedent's Usual Occup	ation		16b. Kind of Business	Industry
ည်	n /2 n "na" n	olete	(Specify only highest grade	completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done i life. DO NOT use retired	during most of work d)	ing		
212	with iene. r thar	Completed	Elementary/Secondary (0-12)	College (1-40r5+)	Student			Schools	
<u>0</u>	be filed within 72 hours after deain with the mayinal tall Hygiene. Ital Hygiene. d other than "natural", or Items 23a or 28a-f ahow event, it a Madical Examination ust be multified at	BeC	17. Father's Name (First, Middle, Last)	unknown		18. Mother's Name	e (First, Middle, I	Maiden Sumame)	unknown
<u>a</u>	should be filed within 72 hours atter death with the maryland ind Mental Hygiene. Ind Mental Hygiene. In a marked other than "natural", or items 23a or 28a-f ahow a marked other than "natural", or items 23a or 28a-f ahow umatic event, It a Madical Examinations to notified at	ToE							
Maryland 21215-0036	d 2 sho th and N t7 Is ma trauma		19a. Informant's Name/Relationship (Type Marni McGarry/Friend	e, Print) 19b. 52	Mailing Address (Street 26 Cromarty Ro	_{and Number or Rur} ad Baltimor	e, MD 2122	; City or Town, State, . 29	Zip Code)
ē,	tem 2		20a. Method of Disposition	cemeter	Disposition (Name of y, crematory or other place		Date	20c. Location - City or	Town, State
io L	ages ant of tt: If i		1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Metro Cr	· · · · · · · · · · · · · · · · · · ·	08-25	-05	Catonsville,	MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licenses	· Ann	22. Name and Addre	ss of Facility 1 Home 638	N. Gilmor	St. Balto, M	D 21217
	# C = # C		23a. Part 1. Enter the disease, or complic	ations that caused the death. Do n					Approximate
			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	105				Interval Between Onset and Death
	'nysician Medical		disease or condition resulting in death)	Due to (or as a configuence of					
	Examiner		- 1	Due to (or as a correspondent	51).				
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):				
>	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
o o	an an an an irial-tr	Exa	resulting in death) Last	Due to (or as a consequence of	of):				
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical	d.						
39	e as t	Med	IF FEMALE:	Bc. If yes, outcome of pregnancy				23d. Date of de	livery
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐Ectopic pregnand 5 ☐ Other (specify) _	у		Month	Day Year
0	the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	0 <u> </u>				
<u>α</u>	requires that the de been signed by the a hould be detached f	by Physiclan/Me	Part II. Other significant conditions con-	tributing to death but not resulting ir	the underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
sp	w requires that been signed to should be det	q p					1 □ Y	es 2. No 3□P	robably 4 Unknown
Vital Records,	> 1 0	Completed					24a. Was a		utopsy findings available completion of cause of
Re	9 F 9	E					perfor	med? death?	s 2 No
ta	iclan: Th certificate rector, pag	a	25. Was case referred to medical			26. Place of Dea	th Check on or	пе	
	S S S	To B	examiner? 1 ☐ Yes 2 XNo	ospital: 1 Inpatient 2 ER/Ou	itpatient 3 DOA			ence 6 Other (Sp.	ecify)
0			27. Manner of Death 1 Natural 5 Pending		Time of 28c. Injury Wo		28d. Describe h	ow injury occurred	
iois	Attending or death. ector: After by the funer	atle	2 Accident investigation]Yes 2□No	206 Leasting (S	treet and Number or F	Rural Route Number
Division of	4 0 77	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		City or Ton		idia riodio ivalisor,
	urs a eral C		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	e death occurred at the t	ime, date and place	and due to the o	ause(s) and manner a	as stated.
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only one)	ner: On the basis of examination ar and manner stated.	nd/or investigation, in my	opinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			se number		29d. Date signed (Mor	ntn, Day, Year)
	_		Fine M. Bron	un, MD	AUHIT	64358166	100	Hugust 1	8 2005
	1		30. Name and address of person who co	empleted cause of death (Item 23a)	(Type, Print)	^/	D 212	O)	,
	0		Erre Brown 2	2 South Green	e >+ Kalt	timore M	D ZIF		
	Si Regis	tate trar	31. Date filed (Month, Day, Year) AUG 2 3 2005	2 South Green	forte				

			Please	Type or Prin				-	•	le.
			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		•	giene _{Reg. No} 201	15 275gn
ı	Physici		1. Decedent's Name (First, Middle, La L0	st) UIS JOSEP	H TRANSF	PARENTI		2. Date of De Month AUGUST	ath	3. Time of Death 7:30 A. M
ı	/Medio		4a. Facility Name (If not institution, giv STELLA MARIS, 2	e street and number) PANGBORNE			r Location of Death	7.00001	4c. County of	
	Funeral		5. Social Security Number 6. S	Gex 7. Ag	e (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07-06-		9. Birthplace (State or Foreign Country) MARYLAND
	Director		Usual Residence of Decedent 10a. State 10b. County	AA	87 Yrs.			0/-06-	-1918	
	e Maryla ta-f shot	ctor	MD. HARF	ORD	100. City, Town or I		TOWNE			10d. Inside City Limits 1 ☐ Yes XX No
	3a or 28	i Director	10e. Street and Number 580 A. RENEE	DRIVE		10f. Zip Code	21085		10g. Citizen of Wh	nat Country?
396	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cubin		ecify Yes or No Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. WHITE
15-0	n 72 hou "neture edical E	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	during most of work	ring	16b. Kind of Bus	iness/Industry
Maryland 21215-0036	filed withi Hygiene. other then ent, the M	Comp	Elementary/Secondary (0-12) 8 YEARS 17. Father's Name (First, Middle, Last	College (1-4or 5	(+)		RIVER		ESSKAY	COMPANY
lanc	should be find Mental H marked of umatic ever	To Be	ROCC		ARENTI		CORF		Maiden Sumame, UNK.)	
Mary	and 2 sho ealth and h n 27 is ma		19a. Informant's Name/Relationship (DALE F.TERZIGNI (ling Address (Street				tate, Zip Code) AND, 21085
ore,	Pages 1 ar nent of Hea int: If item iry or other		20a. Method of Disposition 1 Derial 2 Cremation 3	•.	20b. Place of Disp cemetery, cr	position (Name of ematory or other place	ce)	Date	20c. Location · C	ity or Town, State
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other to QRGE.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices	(y)		SERVICE C 22. Name and Addre RUCK TOWSO	ss of Facility	Antonia marina	105	MARYLAND,21204 O YORK ROAD SON,MD.21204
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		GE DEMENT] a consequence of):	[A				Onset and Death
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	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
68760	cate be e ohysiciar the buria	a	(d						
O. Box 6	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy	/	-	23d. Date Monti	*
۵.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		_	eute to the cause of death?
Division of Vital Records,		Completed						24a. Was autop perfo 1 \(\text{Yes}	rmed? pri	ere autopsy findings available or to completion of cause of ath?
fVit	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatio	ent 3 DOA Oth	26. Place of Deat ler: 4 ♥ Nursing Ho		one) dence 6 □Other	(Specify)
ouo	Attending Physician: or death. ector: After this certification the funeral director.	on:	27. Manner of Death 1 Natural 2 Accident Accident Accident Accident	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	Wor	y at k? Yes 2 □ No	28d. Describe i	now injury occurred	
Divis	after dea after dea Director	Certificati	3 Suicide 6 Could not be determined		ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (5 City or Tox	Street and Number vn, State)	or Rural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Pt	nysician: To the best niner: On the basis o and manner st	f examination and/or i	ath occurred at the tir investigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manr date and place, an	ner as stated, d due to the cause(s)
L	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Month, Day, Year)
•	10t		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	a, Print)	3725		8/3	1405
	0' 1		DR. TARIQ MAHMO	OD 2300 D	ULANEY VAI	LEY RD.	TIMONIUM,	MD 210	93	
* ** **	Sta Registi		AUG 2 3 2	005	ar's Signatura	pare				

	1	For State Registrar		S	tate of	Maryla		artmer <i>rtificat</i>			and M	ental Hy	giene Reg. No :		5	27591
Physician	1	1. Decedent's Nam Ovidio	e (First, Middle, L Valderra	,								2. Date of Dea) 05	3. Time of Death
/Medical Examiner	-	4a. Facility Name (I Holy Cro	f not institution, g OSS Hosp	ive stre	et and numb	per)				Location o	ring			County o		
Funeral Director		5. Social Security N 109-44-9		Sex 1Ã M	2□ F 7.	Age (In yr:	s. last birthday Yrs.	Months Months	n 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt Month, Day 11-15	h 192	7	9. Birth Cou Co I t	place (State or Foreign ntry) imbia S.A.
and *	- h	Usual Residence of 10a. State	Decedent 10b. County			10c. (City, Town or L	ncation								10d. Inside City Limits
Maryla a-f sho		MD	Montgo	nery	7		Silver		ng							tx⊠XYes 2 □ No
with the sor 28s		10e. Street and Nu						10f. Zip	Code	20004	:		-	zen of Wh	nat Cou	ntry?
eath v	3	11. Marital Status	acey ku.	12	Was Decede	ent Ever in	U.S. 13	Was Dece	dent of Hi	20906		city Ves or No	US		- Ameri	can Indian.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inimportent: If time 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Evantinar must be notified at once. To Be Completed by Funeral Director	27		ied 2011 Married		Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ☑ No						cify Yes or No- Rican, etc.) Imbian			, White,	
21215-0036 by within 72 hours attageners at then "neturel; or the marked Exartical Exa	- Indicate	(Spec	15. Decedent's in the cify only highest grandary (0-12)	rade co	ompleted) College (1-4	or 5+)	(Give	dent's Usu kind of wo DO NOT u	erk done d se retired	ation luring most)	of workin	ng		nd of Bus		
Hygie ther ther ther ther there		17. Father's Name	(First Middle Las	:t)	1+			'ailoı	<u>-</u>	18 Mothe	r's Name	(First, Middle,				Industry
Maryland d 2 should be tilt th and Mental Hy it's marked oth treumatic even To Be	í	Melquec:	ided Val	derr			_			Ro	sa M	laria Va	alde	rrama	a	
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Baltii permit. F Departm Importer any injur		21. Signature of Fu	ineral Service Lic	ensee		M003		2. Name ar Rapp	d Addres	s of Facility	Cre	mation	Ser	vice		112
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Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	у опе с	Нуро	volem	ia Shoo									Interval Between Onset and Death
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Ysicien: Thy ysicien: The director, pag		25. Was case refer examiner?	red to medical							26. Place	of Death	(Check only or				
Jn of ding Phys	2	1 ☐ Yes 2√ 27. Manner of Deat 1√√Natural 2 ☐ Accident			oital: 1 🔀 Inp 18a. Date of 1 (Month,		ER/Outpatie 28b. Time of Injury		28c. injury Work	4 🗀 1401	2	ne 5 Resid 8d. Describe h				(y)
Division of To the Hospital or Attending P Within 24 hours after death. To the Funeral Director: Aller t completely tilled in by the tuneral Medical Certification:		3 Suicide 4 Homicide	6 Could not determine		8e. Place of building	Injury - At , etc. (Spec	home, farm, st	reet, factory	, office		2	8f. Location (S City or Tow			or Rura	I Route Number,
Hospi 4 hou Funer ely till		29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	hysicia iminer:	on: To the be On the basi and manner	is of examir	nowledge, deal nation and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a h occurre	nd due to the c	ause(s) date and	and manr place, an	ner as s d due to	tated. o the cause(s)
To the within 2 To the complet	/	29b, Signature and	title of contriler					290	D47			2		signed (Day, Year)
51		30. Name and ad a	iga 470	l Ra	eted cause ando1p	of death (Ite h Rd.	om 23a) (Type Ste 10	Print) 1 Roc	kvi1	le MD	208	52				
State Registrar		31. Date filed (Mon	th, Day, Year) UG 2 3 2	005	41	istrar's Sign	4	ويجده								

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Charles Watson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-5635 AKG State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 20, 2005 August 11:04 Charles Edward Watson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stream near 900 block Alricks Way Baltimore 8. Date of Birth (Month, Day, Year) Aug. 28, 1963 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F Social Security Number **Funeral** 41 Director 218-86-6175 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r then "natural", or items 23s or 28s-f show the Medical Exandrer must be notified at 1X Yes 2 □ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 923 Quantril Way 21205 u. s. A. death v Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ns eny injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) N/A Dependent 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Pilo Frances Nolan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 923 Quantril Way. Baltimore, Md. 21205 Anna Teal (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bauview Crematory 8/24/2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Md. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rowning **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2□ No 24a. Was an autopsy performed? 2 ☐ No certificete 1X Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the function of the funeral director for the function of the function of the function of the funeral director for the function of the function o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at Scene ၉ 1 X Yes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural Susject drowned self 5 Pending Formul 9:15 Found 8/20/05 investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Stream 900 block Alricks Way, Baltimore, MU 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. August 21, 2005

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

2 2 2005 Areas 15 A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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05-05	501		amend item#2	2 per DVR, G846	8/24/0		ne ink. T	Ensure	All	Copies	Are	Legit	ole.	
RJ 			amend item/2 1 - State Unpend Item 2 Registrar		G847 _{Cer}	ilica	05 ta	Death	а ме	піаі ну	gien Reg. N	200	5	27594
	Physicia	an	1. Decedent's Name (First, Middle, Las	1 1.3	1 10			L	2	Date of De Month		ay	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	vara la dimbar	100a	6 C	241	r Location of D		ugust				9:17 p. ^M
	Examin	er	Holy Cross Hospita					Spring	eam		_	o. County o		y County
119	Funeral Director		5. Social Security Number 6. S		. last birthday)		der 1 Year	If Under 24	Hrs. 8. Jin,	Date of Bir (Month, Da	rth ay, Yea	7		place (State or Foreign
	pug &		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Loc	ation								10d. Inside City Limits
	72 hours after deeth with the Maryland 'natural', or Items 23e or 28e-f ehow dical Examinar must be notified at	Director	MD Mouto	gomery	0	In	ey							1 ☐ Yes 2 No
	with t	ā	10e. Street and Number		7	101.	Zip Code	2083	7		10g. C	itizen of W	hat Coul	ntry?
	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	J.S. 13. W	as De		lispanic Origin? an, Mexican, Pi	? (Specif	y Yes or No)-			can Indian,
9	or ite		1 Never Married 2 Married	1 ☐ Yes 2 M No If Yes, Give			pecify Cuba	an, Mexican, Pi Specify:	uerto Rio	an, etc.)			, White,	etc.
Ö	"natural",	q p	3 Widowed 4 Divorced	Year or Dates:								Specify:	WI	rite
75	in 72	plete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decede (Give k	ind of	sual Occup: work done o Luse retired	durina most of	working		16b.	Kind of Bus	iness/In	dustry
212	d within giene. or then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	l'era	mi	cli	le In	sta	ller	7	-100	RIA	VG
Maryland 21215-0036	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 ie marked other than "natu other treumatic event, Ire Medical	To Be C	17 Father's Name (First, Middle, Last)	Wloda		L		18. Mother's	Name (F	irst, Middle	Marge			
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30X	th cer tendir or use	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregr 1☐Live birth 2☐Fet		ctopic	pregnancy				1	23d. Date		•
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ο̈́	s after i Dire	Certification:	4 Homicide determined	building, etc. (Speci	fy)	r, rack	ory, onice		201.	City or Tov	vn, Stat	e)	or Hura	r Addie Walliber,
	lospit hours unera		29a. Certifier 1 Certifyin Phy (Check only 2 X Medical Exam	reician: To the best of my kn iner: On the basis of examin	. wledge, death .	count	d at the tim	ia, date and pla	ace, and	due to the	caupu(e) and man	for we st	alled.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medicai	5/10/	and manner stated.	adon and/or inve				ccurred a	uie ume,				
	SO T WH	~	29b. Signature and title of certifier	1 0		2	9c. License O(CME				ust 1		* * * * * * * * * * * * * * * * * * * *
		ŀ	30. Name and address of person who d	completed cause of death (Ite	m 23a) /Time D	rint)								
t	T			eense or death (the	M,D	art)	111 Pe	enn Str	reet	Balt	imo	re, M	ary1	and 21201
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BERNAR

OZNIAK

Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible. Amend 1tem 20b per 1h 2846 8-23-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 00:29 AM iAMS 2005 /Medical 4b. City Town, or Location of Death 4c. County of Death Examiner Under 24 Hrs. 8 9. Birthplace (State or Foreign s. last birthday, Date of Birth (Month, Day **Funeral** Months Hours Min. 1 M 2 F YS Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or than "natural", or Itema 23a or 28a-1 ehow the Madical Examiner must be notified at Yes 2 □ No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numb Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. tal Status White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 □ Yes a loo Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is marked other than " College (1-4or 5+) opdary (0-12) 18. Mother's Name (First, Middle, Maiden Suma Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or othar trau once. 20b. Place of Disposition (Name cemetery, crematory or other 20c. Location 2 remation 3 For 5 Other (Specify) 1 🔲 Burial 3 Removal from State ^¹ 4 □ Donation 21. Signature of Funeral Service Licensee C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mulhorgen Iday /Medical Due to (or as a consequence of): Examiner 3 days Entero WILL Neevohzuni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy signed by the atte Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 No 1 TYes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Tyes 1 Tyes 2 No To the Hoapital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Nes 2 No Be 26. Place of Death (Check only one) Hospital: Cther: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a, Certifier Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kaul Chaver Value RES -000 08/17/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmer WorkeSt Novil Chavez Valdoz 600 21287 31. Date filed (Month, Day, Year)

AUG 2 3 2005 pgistrar's Signature 32 State Registrar

			For State Registrar	State of Ma	ryland	-		nt of Hotel		and Mo		giene	CHUN	275	97
	Physicia	an	Decedent's Name (First, Middle,			***					2. Date of De Month	Da		3. Time of (_
	/Medic	al	4a. Fecility Name (If not institution,	give street and number			4b. City	, Town, or	Location o	of Death			County of Dea		
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86;	Funeral		5. Social Security Number 6	. Sex 7. Age	i (In yrs. lasi 86	t birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year	9Bir	thplece (State or ountry)	Foreign
	Director		219-98-9118 Usual Residence of Decedent			113.					Sept.	1, I	918 Ch	ina	
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with th	a or 2 be ns	Dire	10e. Street and Number 6121 Montros	e Road				p Code 20852				Chi	tizen of What Co	ountry?	
death	ms 23	Funeral Director	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. V			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ame		
rs after	Health and Mental Hyglene. em 27 ie marked other than "natural", or Items 23e or 28e-f show hther traumatic event, the Medical Examinar must be multied at	by Fur	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? 1	lo		r Yes, spo I⊡ Yes		Specify:	, Pueno P	ricari, etc.)		Black, White		
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DIVISION Lor Attending	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could no 4 Homicide determin		ury - At homo	e, farm, str	eet, facto	ry, office		2	28f. Location (City or To	Street a wn, Stat	nd Number or R e)	ural Route Numb	oer,
	ours a	I Ce	29a. Certifier 15. Certifying	Physician: To the best of	of my knowle	edge death	occurre	d at the tim	e date an	d place, a	and due to the	cause(s	and manner a	s stated	
H	24 h	edical		ceminer: On the basis of and manner sta	examination										
T of	withir To th comp	Me	29b. Signature and title of certifier				_	9c. License				29d. Da	ate signed (Mon	th, Day, Year)	
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1	N		30. Name and address of person w	no completed cause of de	eath (Item 2	За) (Туре,	Print)	Dom	. 50	Doje			BOWL OF	62,50	
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re		1801	E, .	76726	ا دونوی	7	120	1739	
	Regist		都作りり	2005	8 -	S. Carlotte	4.0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Mary Veronica Wilson August 16, 2005 1:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 213-26-1857 1 □ M 2 🖬 F 78 14, 1927 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Bel Air 1 ☐ Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 955 Sablewood Road, Apt. J 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No White Specify: 35 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Carroll Carr Mary Elizabeth Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Leigh Golding/Daughter 1700 Edwin Drive, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Service Corp. 8-19-05 * 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signal of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or ma a consequence of) rice Sequentially list conditions, if any, leading to immediate cause. Enter unuarlying Cause (Disease or injury that initiated exacts) Due to (or as a consequence of) ESRD that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? breceuse 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ✓ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 14 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 LHo 6 Could not be 3 ☐ Suicide

death certificate be executed Box 68760. Physician/Medical signed by the a P.O. Division of Vital Records, 2 Completed Be Certification: To After after death Director; p ō within 24 hours aft To the Funeral D completely filled in the Hospitai

Physician

/Medical

Examiner

Director

Funeral

Completed by

Funeral

Director

th and Mental Hygiene. If is marked other than "natural", or items 23a or 28a-1 ehow traumatic event, the Medical Examiner must be notified at

mit. Pages 1 and 2 should be file partment of Heelth and Mental Hy scritaut: if item 27 is marked oth righty or other traumatic event.

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Deportra
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Physician /Medical

Examiner

filed within 72 hours after death Hygiene.

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Peritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

AG2438922

29d. Date signed (Month, Day, Year)

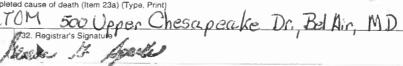
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KURTOM

State Registrar

Medical

29a. Certifie

31. Date filed (Month, Day, Year) AUG 2 3 2005



Wilson,

			1 - For State Registrar	State of Marylan	d / Depa		Health and	Mental Hyg	•	5 27599
	Physici /Medic		1. Decedent's Name (First, Middle, Last) William A. Welnos	sky, Sr.				2. Date of Dea		Year 3. Time of Death 18:50 M
	Examin		4a. Facility Name (If not institution, give s Spa Creek Genesis 5. Social Security Number 6. Sex	Center	last birthday)	Ann		B. Date of Birth		of Death Arundel 9. Birthplace (State or Foreign Country)
	Funeral Director		212-10-8436 103 Usual Residence of Decedent	[M 2 F 94	Yrs.	Months Days	s Hours Min.	(Month, Day Aug. 14	4, 1910	94
	the Maryla 28a-f shov	Director	MD 10b. County Anne Ar 10b. Street and Number		Annapo			1	log. Citizen of W	10d. Inside City Limits 1 Yes 2 No
	s 23e or	erai Di	6701 Whitewater Ct	#204 12. Was Decedent Ever in U	C 12.1	21060	Wannin Orinin 2/6		U. S. A	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show eny injury or other traumatic event, the Medical Examinating resulting at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 X Yes 2 No. If Yes, Give 9 -6 - 28 Year or Dates: 7 - 2 - 3	1 1	f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer D Specify:	to Rican, etc.)		x, White, etc.
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Maryland 2	uld be filed Mental Hygi Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles Velenovsk	у			18. Mother's Na	me (First, Middle, .		
	and 2 sho raith and I n 27 is ma er trauma		19a. Informant's Name/Relationship (Tyn Susan B. Austin /		19b. Mailír 111	g Address <i>(Stree</i> South C	alvert St	reet Suit	r, City or Town, S te 1400	State, Zip Code) 21202 Baltimore, MD
Baltimore,	Pages 1: ment of He ant: If iten lury or oth		20a. Method of Disposition 1 ☐ Buriał 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Bas	Place of Dispo cemetery, crea VVIEW	sition (Name of patory or other pi L'remator	^{асе)} 08-		20c. Location - C Baltimor	City or Town, State e, MD
Ball	Depar Impor eny in		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or compli	92	13	328 Sulp	uneral Ho	g Rd. Ai		MD. 21227
See See	Fnysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	te cause on each line. Due to (or as a consequence)		į	homa	o or rospiratory arr	031,	Interval Batween Onset and Death
8760,	cate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
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S, P	ires sign d be	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to		bute to the cause of death?
I Record	The ate his page	Completed						24a. Was a autops perfort	sy pr med? de	fere autopsy findings available rior to completion of cause of eath?
n of Vital	ding Physicien: Th h. Afler this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H	Iospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time of Injury	28c. inj	ther: 4 ursing h ury at ork?	ath (Check only on dome 5 Reside 28d. Describe he		
Division	or Atten fter deat Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str (y)		⊒Yes 2□No	28f. Location (Si City or Town		r or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, death	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and man late and place, ar	ner as stated. and due to the cause(s)
}	To the within To the comp	Me	29b. Signature and title of certifier	Cvin			nse number			(Month, Day, Year)
_	5		Gorys for	mpleted cause of death (Iter	1 131	Print)	12036 12036	hilm.	4 Cim	16/9
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3	32. Registrar's Signa	ature A	faciles		ŕ		,

State of Maryland / Department of Health and Mental Hygiene
Amend Item 25&27 per me G847 9-1-05-tage of Death

Reg. No. Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00An WOJCIECHOWSKI FRANCES +46 2005 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Chesapeake Arnold Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Yeer) Sept. 14,1919 Birthplace (State or Foreign Country)
 NJ 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Days 1 □ M 2 1 F 85 220-09-9681 Yrs. Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County Itam 27 is marked other than "natural", or items 23s or 25s-1 show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 North Putney Way 21146 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 22 Tho If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after d il Hygiene. other than "natural", or tterr 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: 2 3 Widowed 4 □ Divorced white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 Own Home Homemaker end Mental Hygi permit. Peges 1 end 2 should be file Department of Health end Mental Hy Important: if itam 27 is marked othe any injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Russ Nana (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) son Mr. Edward J. Wojciechowski, Sr. 320 North Putney Way, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 20 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Glen Haven Mem. Park Glen Burnie, MD 21. Signature of Emeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 Pert1. Enter the disease, or complical ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical MYCCARDIAL INFARCTIC Examiner Examine b. CORONARY ARTER
Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown HIP FRACTURE þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 1 Yas DENO 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 5 Pending investigation **V**ENatural 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fo 2 Accident 08/12/2005 1330 P Subject fell 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 2001 Medical Parkway 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Annapolis, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number D57531 ハレーク 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) EGOI l'eterans Hery, Suite 204, Millersville, mp 21108 Negr 32. Registrar's Signature 31. Dete filed (Month, Day, Vear) State AUG 2 3 2005 Registrar

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		•	1 - State Of Registrar	Marylanu	-	tificate of L		менан пу	Reg. NG.	105	27601
			Decedent's Name (First, Middle, Last)			inouto or i	30411	2. Date of De	eath	000	3. Time of Death
	Physicia		Earl Warren					August	Day 20	3005	6:30 AM
F	/Medic Examin		4a. Facility Name (If not institution, give street and num	ber)		4b. City, Town, or	Location of Death			ounty of Deat	
			VABALTIMURE MediCA	al Cen	HeR	BALT	more			NA	
	Funeral		MON OUT	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Year)	Co	nplace (State or Foreign untry)
	Director		219-50-4545 Usual Residence of Decedent	58	113.			July2	4,194	47 Mar	yland
	yland		10a. State 10b. County	10c. City,	Town or Lo						10d. Inside City Limits
	Ba-f s	ctor	MD Baltimore			Middle	River		_		1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	`.		10f. Zip Code	2			n of What Co	untry?
	death with the Maryland ms 23a or 28a-f show criust be rollined at	era	13 Propeller Drive	dent Ever in U.S.	12.1	21220		positiv Von av N	USA	. Race - Ame	rican Indian
_	fter d	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Yes. Give	ces?	1	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	0-	Black, White	
2-0030	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	tes:		I□Yes 2□XNo	Specify:		S	pecify:Whj	te
ה ה	be filed within 72 hours after death with the Marylar ital Hyglene. d other than "natural", or litems 23s or 28s-f show ovent, the Mariteal Everther mast be nutilised at	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wor	king	16b. Kind	of Business/	ndustry
V	within ane. than	d L	Elementary/Secondary (0-12) College (1-	4or 5+)		arpente:			Con	struc	tion
0	filed Hygid Sther ent,	ပိ	12th 17. Father's Name (First, Middle, Last)			ar peneer	18. Mother's Nar	ne (First, Middle	, Maiden S	umame)	
Maryland		To Be	HArry Warren				Dolo	res St	apli	per	
ar	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Ru	iral Route Numb	er, City or	Fown, State, 2	lip Code)
e, ≅	5 2 5 5 5		MAry Ann Warren /wi			Propell	ler Dri				
	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from S	tate cer	metery, cren	sition (Name of natory or other plac		Date		ation - City or	
Баппо	rtmen rtant: njury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 	Ва		Cremat		22/05	Bal	timor	e MD
g	permit. Pages Department of I Important: If ite any injury or o		21. Signatury of Pulleral Service Literasee	_ 11.	, 22	. Name and Addres	C		-		meofEssex
			23a. Part1. Enter the disease, or corperications that ca shock, or heart failure. List enty one cause on ea	used the death.	Do not ent	300 M er the mode of dying	lace Ave g, such as cardiad	Bal: or respiratory a	timor arrest,	e MD	Approximate
	Physician [*]			Lymphei							Interval Between Onset and Death
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a conseque	ence of):						
•	be executed iician and burial-transit	хап	that initiated events	or as a conseque	ence of):						
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ĝ	tificate ig phy as the		U.								
X Q Q	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant	come of pregnand		Ectopic pregnancy			23	d. Date of deli	,
	ie dea the at hed fo	sicl	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves 2 No	ant at time of dea wn	ath 5□	Other (specify)				Month	Day Year
Ţ	that the	Ph)	Part II. Other significant conditions contributing to de	ath but not result	ting in the u	nderlving cause give	en in Part I.	23e, Did	tobacco use	e contribute to	the cause of death?
g,	uires signi	d by				100			Yes 2 ₩	,	obably 4 Unknown
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	eician: The law certificate has b irector, page 2 si	оше						auto perf	opsy ormed? 2 No	prior to death?	completion of cause of
VITal	10 7	BeC	25. Was case referred to medical examiner?				26. Place of Dea				20.10
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ISION		ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At hon	ne. farm. str	eet, factory, office	Yes 2 No	28f. Location	(Street and	Number or Ru	ral Route Number.
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	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by		29a. Certifier 1 Certifying Physicien: To the	best of my know	ledge, death	occurred at the tim	ne, date and place	, and due to the	cause(s) a	nd manner as	stated.
	the Ho in 24 the Fu	Medical	(Check only 2 Medical Examiner: On the ba one) and mann	er stated.	on and/or in	estigation, in my of	pinion, death occu	irred at the time	, date and p	lace, and due	to the cause(s)
	To To t	Σ	29b. Signature and title of certifier			29c. License	e number		29d. Date	signed (Monti	n, Day, Year)
	1.		year on is			PI	1752		81.	0/05	
1	11 by		30. Name and address of person who completed cause	of death (Item :	23a) (Type.	Print)	11 5400	+ RA	11'm	ne o m	0 21201
	Sta	atė	31. Date filed (Month, Day, Year) 32.	egistrar's Signatu	ire 7	Print) DRY CA	JUNIO E	1 14	Tille	, CF , 11° -	1 - 1 - 1
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TOTAL PROPERTY AND AND AND AND AND AND AND AND AND AND		Physici	an									Month	Day	Year	3. Time of Death
Social Security Foundation Social Securit	18			4a. Facility Name (If not institution, g	ive street and number	0 11	imore	0 1	1		of Death	Avgust	-		
Total December Tota				5. Social Security Number 6. 072-36-3904	Sex 7. A	ge (In yrs.	last birthday)	If Under	1 Year	If Under		2. Date of Bir (Month, Da 05-25-1	th 1944 944	Cou	intrvL
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Physician (Medical Examiner Medical Examiner) The Clical Examiner (Medical Examiner)	00	8358		Jumerla	pres									alto,MD	21217
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Acam Carrinci MD Sinai Huspital of Baltimore	o	ding th. : After s fune	tion	1 ☑Natural 5 ☐ Pending	(Month, D	ay Year)						200. 2000.120	now injury of	courrod	
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Adam (ani- MD) RES-000 August 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adam J Carinci, MD Sinai Huspital of Baltimore		ne Hospit n 24 hour ne Funera		(Check only 2 Medical Ex	aminer: On the basis	of examina	owledge, deal ation and/or in	th occurred evestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and pla	d manner as ace, and due	stated. to the cause(s)
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Adam J Carinci, MD Sinai Hospital of Baltimore		1.		1 Holan	(ami	- /	ND	1	(L)	>-O	UL)	Augu	ist 2	1,2005
7,000,00		10		30. Name and address of person wh				_	Sin	ai H	Lush	ital à	f B	altim	010
State 31. Date filed (Month, Day, Year) 32. Registrar's Signafure Registrar ALIC 9 9 2005				31. Date filed (Month, Day, Year)	32. Regis		, ,			1		<u> </u>			

Jean Woods

ORIGINAL

			For State Registrar	State o	f Marylan		artment <i>tificate</i>			and M		giene Reg. NQ			276	03
	Physici	an	Decedent's Name (First, Middle MATTHEW		P N						2. Date of De. Month	Day		ear	3. Time	of Death
	/Medic		4a. Facility Name (If not institution	ALL!			4b. City, To	awn ar	Location	of Death	August		, 200 County of I		1:	50p м
	Examin	er	Saint Thomas			Home			vil.				ince		0000	2.6
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	Year	If Under:	24 Hrs.	8. Date of Birt					or Foreign
	Director		238-26-8266	1 ∰M 2□ F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da May 5,	1925		Count	NC	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. inside C	City Limits
	f sho	ō	DC			Washir										s 2 No
	7.28e	Director	10e. Street and Number				10f. Zip C					10g. Citi	zen of Wha	at Count	ry?	
	23a o	ai D	2855 Bladenst	ourg Rd.	NE		200	18					USA	A		
	r dea	Funeral	11. Marital Status	Armed Fo	edent Ever in U	.S. 13. \	Was Decede	nt of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race -	America White, e		
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ē,	s 1 and 2 f Heelth ltem 27 l		20a. Method of Disposition			lace of Dispo	sition (Name	e of			ate		cation - Cit			
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heeli Importent: If Item 2 any injury or othar once.		1 🖾 Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S			emetery, cren intico				/12,	/05	Tri	ang 1	e , '	Vа	
alti	apartn sporte sporte y injt		21. Signature of Funeral Service	Licenseen 2	1.1.	Q 22	. Name and	Addres	s of Facilit	у В 1 г	uford	Fun	eral	Se	rvic	e
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			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.						r respiratory ar	rrest,			Approxima Interval Be	etween
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9	death certific attending pl	/Mec	IF FEMALE:	000 16												
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?		come <i>o</i> f pregna irth 2 □ Feta ant at time <i>o</i> f d	I death 3	Ectopic preg					2	3d. Date of Month		•	Year
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Д.	requires that the peen signed by th hould be detache	by Pt	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the ur	nderlying cau	ıse give	n in Part I.		23e. Did to	obacco u	se contribu	te to the	cause of	death?
rds	w require been sig should b	ed b	Cerebrova	scular o	isense						1 🗆 1	/es 2[]No 3[] Proba	bly 4 🗷	Unknown
ooa	aw Is b	plet	Hypatens,	in D	Labet	es me	Mitu	9			24a. Was		24b. Wer	e autop:	sy findings	available
Division of Vital Records,	The ate h page	Completed										rmed? 2 No	prior deat	h?	pletion of a 2□ No	cause of
/ita	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
of	S 0 1	2	1 Yes 2 No 27. Manner of Death		npatient 2				400 1401		ne 5 🗆 Resid			Specify)		
OU		tion	1 Natural 5 Pendin 2 Accident investig	3	h, Day Year)	28b. Time of Injury	M 280	C. Injury Work	at ? ′es 2⊡N		28d. Describe h	now injury	occurred			
/isi	I or Attendate death Director:	ifica	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	ome, farm, stre			03 20,	-	28f. Location (S	Street and	l Number o	r Rural	Route Nur	mber
Ö	safter safter of Director of in by	Certification:	4 Homicide determ	buildii	ng, etc. <i>(Specif</i>)	y)					City or Tow	vn, State)				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral	edical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the ba	best of my kno	wledge, death	occurred at	the time	e, date and	d place, a	and due to the	cause(s)	and manne	r as sta	ted.	
	the hin 24 the f	Medi		and main	ner stated.					.n occurre						s)
	To To		29b. Signature and title of certifier	2/	3/-		!		number 2 2	708			signed (M			
Δ	0	1	30 Namo and address of	who completed in	001 00000000000000000000000000000000000	00-1 ~		90	7-	0		٥	1.	~ ,	-	
K	(2)		30. Name and address of person				,	G E	TAT ~ C	hina	ton D	2 20	1032			
	Sta	te	Zonozi Me 31. Date filed (Month, Day, Year)					0.5	• was	urriid	COIL D.C	Z(1002			
	Registr	ar	AUG 1 0 21	005	w K	Span										

1	-	For State Registrar
1	-	O

State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar		Ce	rtificate of	Death		eg. Non	
	/sicia ledic		1. Decedent's Name (First, Middle, Las DOROTHY	AND	ERSON	J		2. Date of Dea Month		S 12:15 PM
	min		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of De	
		4-	University of Maryland			Baltim			NA	
Fune Direc			5. Social Security Number 6. So. 579-54-1417	ex 7. Age (li □M 2∏XF	n yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year) C	rthplace (State or Foreign country)
	, LOI		Usual Residence of Decedent		-			JULY 15,	1940 [[AL]	LADEGA, AL
laryland	=		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
e Ma	IIII B	cto	MARYLAND PRINCE GI	EORGE'S	TEMPLE	HILLS				Yes 2□No
th with th	AST DE TIE	al Director	10e. Street and Number 3911 LEISURE DRIV	JE		10f. Zip Code 2074	8-1822	1	0g. Citizen of What C	ountry?
in any small of the filed within 72 hours after death with the Maryland for Health and Mental Hygiene "natural", or Items 23e or 28e-f show	Aziminar m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:	
72 hou	3	ted	15. Decedent's Ed (Specify only highest grain	ucation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	s/Industry
ithin 7		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	NITA OF WORK DONE DO NOT use retire	during most of worki			
led w lygien	1		47. 5-41-1-11-11-11-11-11-11-11-11-11-11-11-1	1YR.	CLAI	MS EXAMI				PTFED.GOV
and Mental Hygiene.	stic ever	To Be	17. Father's Name (First, Middle, Last) WILL NABORS				18. Mother's Name BESSI	e (First, Middle, I E WILLI	,	
	E		19a. Informant's Name/Relationship (7						, City or Town, State,	Zip Code)
t and Health em 27	ther		LOUIS ANDERSON/ E				DR. TEMPI			8-1822
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is	0		1 ☐ Burial 2 TCremation 3 ☐	nomovan nom otato	20b. Place of Dispo cemetery, crei		1		20c. Location - City o	
it. P.	C a		4 □ Donation 5 □ Other (Specify21. Signatule of Funeral Service Licenses				MATORY 8-9		LEXANDRIA,	VA
permit. Departmin	any conce		X Walland	X Joa			LAND RD.		FUNERAL H	
Physic /Medi	_		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the one cause on each line. a	death. Do not ent	er the mode of dyi				Approximate Interval Between Onset and Death
executed by and		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cue to (or as a co						
icate be	and en s	Medical		d						
the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. of the Funeral Director: After this certificate has been signed by the attending physician and	ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	olivery Day Year
that	gera	by Pr	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
w requires been sign		d be	Acute renal -	failure				1 □ Ye	es 2 No 3 P	robably 4 Unknown
e law re	V	Completed	Respiratory.	failure				24a. Was a autops		utopsy findings available completion of cause of
The The	page	Con						perform	ned? death?	s 2 No
ician: Th	5	Be	25. Was case referred to medical examiner?	Manitati .		75.	26. Place of Death	(Check only on	9)	
Physi this o	=	2	1 165 2 140	Hospital: 1 Inpatient	2 ER/Outpatien	IL SELDON			nce 6 Other (Spe	ecify)
anding Path.	me runera	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a, Date of Injury (Month, Day Ye	28b. Time of Injury	Wo	ryat rk? Yes 2□No	28d. Describe ho	w injury occurred	
el or Att	ka u	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A		edical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of miner: On the basis of exa	amination and/or in	n occurred at the til vestigation, in my o	me, date and place, a opinion, death occurre	and due to the ca ed at the time, da	iuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
To th Withir To th	duios	M	29b. Signature and title of certifier			29c. Licens	se number	25	9d. Date signed (Mon	th, Day, Year)
-			1 gan 6	me n	10	PI	6629		Aug 5	, 2005
R6)		30. Name and address of person who c				S+ RAI	hmore	MAD 2	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

AUG 0 9 2005

	انسو	1	For State Registrar 1. Decedent's Name (First, M.	iddie, Last		of Marylai	•	artmer rtificat					Reg. N	000	27605
/!	ysicia Medic	al -	Haze1 L 4a. Facility Name (If not institu	ouise	Botel			4h City	Town or	Location		Month August	7 ,	y Year 2005 County of Dea	03:19 A M
	amino	1	Prince George 5. Social Security Number		spital	Cente	r . last birthday)	C	hever	1y If Under	24 Hrs.	8. Date of Bi	P ₁	rince G	
Dire	ctor		220-12-3794 Usual Residence of Decedent		_M 2 - g_F	80	Yrs.	Months	Days	Hours	Min.	(Month, Da		924 Mar	ountry)
the Marylan	notified at	Director	10a. State 10b. Cot Iaryland Prin 10e. Street and Number	1	eorge's		ity, Town or Lo		p Code				10 g . Ci	tizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ★No country?
IC X IX IS-DUCSO filed within 72 hours after death with the Maryland Hyglene. other than "natural", or Items 23a or 28a-f ahow	or other treumatic event, the Madical Exercit at true Laurdilled at	by Funeral	3400 Mor1ock 11. Marital State 1 □ Never Married 2□ ! 3 ₩ Widowed 4 □ Divor	Married	Armed F	2 X No ive				ispanic Ori n, Mexicar		cify Yes or No Rican, etc.)		S.A. 14. Race - Am Black, Wh	ite, etc.
I within 72 he lene.	the Medical	Completed	15. Dece (Specify only his Elementary/Secondary (0-1 12		le completed,	1-4or 5+)		dent's Usu kind of wo DO NOT u	ork doné d ise retired	ation during mos	st of workin	ng	16b. K	ind of Business Domest	
narytano 2 should be filed n and Mental Hyg 1s marked other	atic evant,	To Be C	17. Father's Name (First, Mid Avener S. K							An	na Ke	(First, Middle			
c, s t and teatth	other treum		19a. Informant's Name/Relati Linda Ringer— 20a. Method of Disposition			20b.	1010	00 Ma	rguei	rita .	Ave.		lale,	or Town, State, MD 20 ocation - City o	769
partimore permit. Pages : Department of H Importent: If ite	any injury or c once.		b Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Sen	r (Specify,)	State Fo	rt Line	coln (Cemet	ery			Bre	entwood Funeral	, MD
Physical and physician and phy	dical liner	dical Examiner	23a. Part. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e, or comp List only o	a. SE Due to Due to	caused the dealer ine. PS IS (or as a consection of the accuracy of the accu	equence of):			,		r respiratory a	arrest,		Approximate Interval Between Onset and Death
death certifi	or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes > No 9 ☐ Unknown		1 Live	utcome of pregr birth 2 Fer nant at time of nown	tal death 3	⊒Ectopic p ⊒ Other (s						23d. Date of de Month	elivery Day Year
requi	pe o	þ	Part If. Other significant con	ditions co	ntributing to o	death but not re	esulting in the u	underlying	cause give	en in Part I	l.		Yes 2	2 00 3 □ F	to the cause of death? Probably 4 Unknown autopsy findings available
The la	or, page 2	3e Completed	25. Was case referred to me	dical						26. Place	e of Death	auto	opsy ormed?	prior to death?	completion of cause of
OVINITION OF ON Attending Physiter death.	in by the funeral di	Certification: To B	3 ☐ Suicide 6 ☐ Co		28a. Date (Moi		28b. Time of Injury home, farm, st	of M	28c. Injury Work 1 🔲	4 141	No 2	28d. Describe	how inju	nd Number or F	ecify) Rural Route Number,
Hospite 4 hours Funerel	ely filled	edical C	29a. Certifier Certifier (Check only one)	ifying Phy ical Exam	iner: On the	e best of my kr basis of examin	nowledge, deal	th occurred	d at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s , date an) and manner a d place, and du	is stated. le to the cause(s)
To the within 2	lwoo)	M	29b. Signature and title of ee	1	Ompleted cau) use of death (fte	em 23a) (Type	D	OS 5)		29d. Da	te signed (Mon	ith, Day, Year)
	Sta	te	31. Date filed (Month, Day, Y	TIN.	30		pital		Che	ever	y i	up 20	078	5	

				State of Maryla		artment of I <i>rtificate of</i>		fental Hygiei Reg.	000	5 27606
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> REBECCA	Α.	BR	OWNE		2. Date of Deeth Month	Day Ye	11.
	Examir		4a Fecility Name (If not institution, give Prince Georges		& Nursi	ng Home	4b. City, Town, or Lo	ocation of Deeth	4c. County of D	
	Funeral Director		5. Social Security Number 6. Security Number 220-08-2007 Usual Residence of Decedent	x 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye. 10-31-	9.	Birthplace (State or Foreign Country) LIBERIA
	anylend show		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	the Maryle 28s-f shor	ctor	MD PG		Ne	w Carro	11ton			1 A Yes 2 □ No
	death with the Marylend rms 23e or 28æ-f show rmst be notified at	rai Dire	10e. Street end Number 5913 85th P1.			10f. Zip Code 2 0	784	10g.	Citizen of What US	•
020	urs after al', or ite	Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 27☐ No If Yes, Give Year or Dates:		Vas Decedent of I I Yes, specify Cub I □ Yes 🍇 📆 No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, /hite, etc. Black
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours Depertment of Health and Mantal Hygiene. Important: If Itam 27 is marked other than "natural", any injury or other treumatic event, the Medical Exappres.	mpieted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> Colle g e (1-4or 5+)	16e. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retire Housew	during most of work d)	16b.	Kind of Busine	•
land 2	uld be filed fantal Hygir ked other tic event, I	To Be Co	17. Fether's Name (First, Middle, Last) Unkno	own			18. Mother's Name	(First, Middle, Maid 1known		
	ind 2 shou aith and N 27 is mei ir treumei		19a. Informant's Name/Relationship (Ty Reginald Browne,	pe, Print) Son	19b. Mailin 5 9 1 3	g Address (Street 85th P	and Number or Rura	al Route Number, Cit Carroll t	or Town, State	e, <i>Zip Code)</i> D 20784
Baltimore,	Pages 1 a nant of Her ant: If itam ury or othe		20a. Method of Disposition POSurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State G	Place of Dispos cemetery, creme eorge V	sition (Name of natory or other pla Vash. C		3-20-	Location - City $2 \ln h$ i.	
Balt	permit. Depertimport any inj		21. Signature of Funeral Service License	DV/18	1 7	Name and Addre	ess of Facility Tay	lor's Fu	neral W Was	Home hington DC
	Physician /Medical Examiner	ler	23a. Pari 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Antenios		re Car			: Jeans	Approximate Interval Between Onset and Death
(09289)	The law requiras that the death certificeta ba assecuted ste has been signed by the attending physician and paga 2 should be detached for use es the buriel-transit	Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consequ					
Вох	attending for use	lan	d					/		
, P.O.	that the da led by the a detached i	y Physic	Part II. Other significent conditions con-	0 5	esulting in the un	derlying ceuse giv	en in Part I.	23b. Did tobeco		te to the cause of death? Probably 4 Junknown
Records,	aw requiras tha is been signed 2 should be del	Completed by Physician/N	Dementia					24a. Was an au performed?		b. Were autopsy findings available prior to completion of cause of death?
al R			Drug hadera	with Gas	mie +	v be Fo		1∐ Yes	2 et No	1 ☐ Yes 2 ☐ No
f Vital	2 00 10	To Be	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Oth	er: 4 Nursing Hon	(Check only one) ne 5 ☐ Residence	6 ∏Other (S.	pecify)
ion of	After fune		27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how in		occiny)
Division	\$ \$ \$ 5 €	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office	2	28f. Location (Street a City or Town, Sta		Rural Route Number,
	Hospital 124 hours Funeral Idetely filled	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my kner: On the basis of examinand manner stated.	owledge, death ation and/or inve	occurred at the tinestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cause and at the time, date a	s) and manner nd place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple		29b. Signature and title of certifier	0 -		29c. Licens	_		ate signed (Mo	
			Panelin	Selve	m		1852	17.	29057	8 2005
R	(2)		1130- /12	E MD 4203	Quee	rint)	Rd Hy	attsuille	MD	8 2005 20781
.0	Stat Registra	е	31. Date filed (Month, Day, Year) AUG 1 0 2005	32. Registrer's Sign	neture	.,				

DHMH 16 Rev 6/95

			1 - For State Registrar		Maryland / [-	ment of F ficate of			R	ag. 2.0	05 2	27607
	Physicia /Medic		Decedent's Name (First, Middle Germaine Bell	Brown						2. Date of Dear	_ეგ2	^Y °05	3. Time of Death 11:25 AM
	Examin		4a. Fecility Name (If not institution Holy Cross Ho 5. Social Security Number	spital	ar) Age (In yrs. last bir		b. City, Town, c Silver f Under 1 Year	Spring	J	8. Date of Birth	Mont	nty of Death GOMERY 9. Birthpl	lace (State or Foreign
	Funeral Director		578-34-0281 Usual Residence of Decedent	1□ M 2XF		Yrs.	fonths Days	Hours	Min.	(Month, Day) 10–25–2	, Year) 27	Wash	ington DC
	he Marylar 28a-f show	Director	MD 10a. State 10b. County Print 10e. Street and Number	ice Georges	10c. City, Tow Capit	col H	eights			1	On Citizen	of What Coun	0d. Inside City Limits 1X Yes 2 □ No
	h with t	al Dir	804 Mentor Ave	enue		•	20743				USA	or what coun	uy:
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show digal Evantret must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ss? XINo		s Decedent of Fes, specify Cub	lispanic Orig an, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	E	Place - America Black, White, e Black	etc.
21215-0036	⊆ 2	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12th			(Give kin	t's Usual Occup d of work done NOT use retire ISOY	during most	of working	9	16b, Kind o	f Business/Ind I O.E End	graving &
nd 2	be filed withintal Hygiene. Id other than evant, the M	Be C	17. Father's Name (First, Middle,							(First, Middle, I			
Maryland	2 should and Mer Is marks aumatic	To	Fletcher Rosse 19a. Informant's Name/Relations Lloyd D. Brow	hip (Type, Print)		_	Address (Street	and Number	r or Rural		-		
	Pages 1 and 2 nent of Health int: If item 27 iry or othar tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from Sta	20b. Place o	of Dispositi		ce)	Da	-	20c. Location	on - City or To	wn, State
Baltimore,	permit. Pages Department of Important: If it any injury or o		4 ☐Donation 5 ☐ Other (S 21. Signature 1 Funeral Service		Paral	22. N	lame and Addre	ss of Facility					
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	sed the death. Do h line.			ng, such as o	cardiac or	respiratory arr	est,	2	Approximate Interval Between Onset and Death Omins
	/Medical Examiner		resulting in death)		as a consequence								7 days
	p #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence								
8760,	ate be executed hysician and the burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (or	onary ede asaconsequence t Respira	of):	distre	ss syn	ndrom	je			days 7 days
9	tificate ig phys	fedic		d							-		
O. Box	aath cer attendir for use	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		n 2 ☐ Fetal death t at time of death		ctopic pregnanc ther (specify) _	У				Date of delive Month	ry Day Year
Δ.	w requires that the d been signed by the should be detached	by	Part II. Other significant condition	ons contributing to deat	h but not resulting i	in the unde	erlying cause gr	ven in Part I.		_	bacco use c		e cause of death?
Il Records,	The ate h page	Completed								24a. Was a autops perform		prior to con death?	psy findings available inpletion of cause of 2 No
Vital	Phyaician: The this certificate hiral director, page	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 ER/O	utnationt	3□ DOA Ott			(Check only onle 5 ☐ Reside		Other (Specific	4)
of	Attanding Physic death. actor: After this by the funeral di	\vdash	1 Yes 2X No 27. Manner of Death 1 X Natural 5 Pendir 2 Accident investi	28a. Date of (Month,	Injury 28b.	Time of Injury	28c. Inju Wo		21	8d. Describe h			7
Division	Dir Dir	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined 286. Place U	Injury - At home, fa , etc. <i>(Specify)</i>	arm, street	t, factory, office		2	8f. Location (Si City or Town		imber or Rura	l Route Number,
	To tha Hospital within 24 hours of To the Funaral completely filled	edical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the base and manne	s of examination ar		stigation, in my	opinion, deat		d at the time, d	late and plac	ce, and due to	the cause(s)
	To with	Z	29b. Signature and title of certifie	ie Mic	Keus	rec	DUC	se number	368	2	9d. Date sig	ned (Month, I	Day, Year)
2	(B)		30. Name and address of person Deanne McKenzi	who completed cause Le 5100 Aut	of death (Item 23a) h Way Sui	(Type, Pri Ltland	d, MD 2	0746					
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 0 2		ristrar's Signature	Great	2)						
DH	MH 17 Rev 1/2	001		1			-						

			ype or Print in Bla State of Maryland									
		1- State of Maryland / Department of Health and I Certificate of Death					i,a moman i i	Reg. NO 105 27600				
no.		Hegistrar 1. Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of Death			
Physi	ician dical	Dorothy Evans	Dorothy Evans Bock				Month Augus			st 5, 2005 7:00P M		
Exam		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				. County of Deat	th	
		Civista Medical	A 6 1-06 -1	La Plata If Under 1 Year If Under 24 Hrs. 8, Date of Birth					Charles 9. Birthplace (State or Foreign			
Funera Directo		5. Social Security Number 6. Sex 15	7. Age (In yrs. las M 2XF 85	Yrs.	Months	Days	Hours	Min. 8. Date of Bi	3 (Year)	1920 0	ountry) TX	
ס		Usual Residence of Decedent										
show	5	10a. State 10b. County 10c. City, Town or Location Newburg								1 ☐ Yes 2X No		
the M	rect	10e Street and Number 10f, Zip Code 10g, Citizen of What								ountry?		
ING XIX 13-0030 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or Items 23a or 28a-f show event, it e Medical Exerciter russ the retition at	Funeral Director	14092 River Rd. 2066					0664	US.				
r deat	ıner	Tr. Maria Olato	12. Was Decedent Ever in U.S. Armed Forces?	Ever in U.S. 13.		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto			0-	14. Race - American Indian, Black, White, etc.		
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ➡No Specify:					Specity: White			
A I A I S-UUSO od within 72 hours af gjene. er than "neturel", or ure Medical Existin	ted t	15. Decedent's Education 16a.			Decedent's Usual Occupation				16b. K	6b. Kind of Business/Industry		
thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired) Homemaker				Home			
iled wi		17. Father's Name (First, Middle, Last)						's Name (First, Middle	. Maidei	Maiden Sumame)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be inclined at	To Be	John Edward Evans			Laura Almina Wight							
Maryland Id 2 should be file Ith and Mental Hy 77 Is marked oth traumatic event	-	19a. Informant's Name/Relationship (Type, Priot) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,										
and 2 and 2 ealth m 27 I					2 Bea		Have	n Cir. N		ocation - City or		
DOFE iges 1 if ite		20a. Method of Disposition 1 Burial 2 Feremation 3 F	emoval from State Bril	netery cre	matory or of e I d - I	ther place	ls C				otte Hall	
Baltimore , cormit. Pages 1 ar Department of Heal Importent: If item any injury or othe		21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, PA										
Dep de y	OUCO	1 1 1 1	4 2000	945	AREH <i>A</i>	RT-	ECHO	LS FUNER	AL I	HOME, PA -20646	A.	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death.	Do not en	ter the mode	e of dying	g, such as	cardiac or respiratory	arrest,	20010	Approximate Interval Between Onset and Death	
Physicia		Immediate Cause (Final disease or condition RES PIRATORY FAILURE							Onset and Death			
/Medic Examine		resulting in death)	Due to (or as a conseque	nce of):	MM	Λ/.	<u>1</u>					
cuted nd iransit	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						1.	1		
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events	Tonque Carcinoma w						ny	nets		
0 m 7	Ĭ,	resulting in death) Last	Due to (or as a continuous of):									
Box 68760, eath certificate be exe attending physician a for use as the burial-1	edical		DYSPH	DYSPHO IN								
OX 6 certifi ding	/Me	IF FEMALE: 23b. Was decedent pregnant	33c. If yes, outcome of pregnancy 1						23d. Date of delivery			
death cert e attendin	iclai	in the past 12 months?					Month Day Year					
I Records, P.O. Box 6876U, The law requires that the death certificate be ex tte has been signed by the attending physician a page 2 should be detached for use as the burial	Physiclan/M	9 Unknown								o the cause of death?		
ds, iires th signed d be do	Š	1 Type 2 This 3 Terminating to death bat not resulting in the ancestying eaces given in that it.										
COrd * requir been si should	etec					_		24a. Wa		HOLES-IC	utopsy findings available	
I Records, The law requires t ate has been signe	ompleted							aut	opsy formed?	prior to death?	completion of cause of	
	O	25. Was case referred to medical		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ 26. Place of Death (Check only one)						2 140		
- > º o	To B		Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6						6 □Other (Spe	ecify)		
		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury			28c. Injury at Work?			28d. Describe how injury occurred			
er at a	ट	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	M 1 Yes 2 No			28f. Location (Street and Number or R		ural Route Number,			
Division I or Attending after death. I Director: Afte	Certification:	4 Homicide determined	building, etc. (Specify)	eet, ractory, ornoe			City or To					
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical C											
To the H within 24 To the F	Medi	one) 29b. Signature and tyle of certifie	and manner stated.				e number			ate signed (Mont		
To To		230. Signature and the or certified	1004			D-57				8 - 7 -		

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abbas A. Omais, MD Cenna Medical Center 7-C Post Office Road Waldorf, Md. 20602

31. Date filed (Month, Day, Year)

AUG 0 9 2005

AUG 0 9 2005

Registrar

			For State Registrar	State of Ma	-				iental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, La	act)		Certificat	e of De	atn	2. Date of De	Reg. No.	005	3 Pmah haah)
	Physici	an	(1)			,			Month	Day	Year	3. Ime of beath C
	/Medic Examir		4a, Facility Name (If not institution, gir		OWN		Town, or Loc	ation of Death	8	9 4c. Cour	nty of Death	0715
	Examir	er	(1)	word Medi	al Can		1156		,		com	100
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birti	nday) If Unde	r 1 Year If	Under 24 Hrs.	8. Date of Bir			ace (State or Foreign try)
	Director		218-20-4286	1□M 2▼F	50 1	rs. Months	Days H	ours Min.	8. Date of Bir (Month, Da	9-1925	M	3
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						Od. Inside City Limits
	anyla shov	<u>~</u>			101 -102		-					1 12 Yes 2 □ No
	he M	ect	10e. Street and Number	Conico	1191	dela	Code	1195		10g. Citizen o	of Mihat Cause	
	with	j	11312 San Do	0	1.	2		27		U. 3		uy:
	death with the Maryland ms 23a or 28a-f show r must be millied at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.				ecify Yes or No Rican, etc.)		ace - America	an Indian,
36	72 hours after death with the Marylan natural', or Items 23a or 28a-f show dical Examinat must be millied at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			cify Cuban, N 2 No Si		Rican, etc.)	Spec	lack, White, e	ACK.
5-0036	72 hou natura	Completed	15. Decedent's 8	ducation	16a.	Decedent's Usu (Give kind of wo life. DO NOT L	al Occupation	n most of work	ina	16b. Kind of	_	lustry Factory
21	d within 72 ho piene. Ir than "natu	nple	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+	.)	-			mg	1.		,
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nd	be filed ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Las	•					e (First, Middle,		,	ž
<u> </u>	y Mer narke	L C	Rhuel E. G 19a. Informant's Name/Relationship		405	Mailine Address			a B.			Code) 2/837
Maryland	d 2 should th and Mer ?7 is marke traumatic		JASON Brown									ings MD
Ġ,	1 and Healt tem 2		20a. Method of Disposition	7 - 17 CES ROLL	120b. Place of	Disposition (Na	me of	20111119	Date	20c. Location	n - City or To	wn, State
no I	ages ant of t: If if		4 □ Donation 5 □ Other (Spec			, crematory or		8/1	3/00	5600	7	UMD
Baltimore	nit. Pa vartmen ortant: injury ie.	1	21. Signature of Funeral Service Lice		1-1000	22. Name a	nd Address of	Facility 15	ennie	300	b Fu	neral Hame
Ba	permit. Departm Importa any inju	1) (July	5 for					- Sal,			
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	notications that caused to	he death. Do n							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Renal	<u> </u>	æ						Onset and Death
}	/Medical		resulting in death)	a	consequence of	f):	1			1 ^		11 0
	Examiner		Sequentially list conditions	b. Cardio	ic a	roesti	MYOC	ardial	intere	. Non		4 days
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	f):		1 sont	per			7. kg
	and -trans	Examin	that initiated events resulting in death) Last	c. Pagur	consequence		eura	1 1751	pai	<u> </u>		JUKS
60,	sician and burial-transit			540 10 (01 43 4		,,.			•			
68760	ificate be execul g physician and as the burial-trar	edical	•	d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. (Date of delive	rv
Вох	death certi attending of for use a	Physician/M	in the past 12 months?	1□Live birth 2 4□Pregnant at t		3 □Ectopic p 5 □ Other (s						Day Year
o.	that the de led by the a detached f	hysi	1 Yes 2 No 9 Unknown	9□ Unknown								
ď	The taw requires that the death certite has been signed by the attendingage 2 should be detached for use	by P	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying	cause given in	Part I.	23e. Did t	obacco use co	ontribute to th	e cause of death?
rd	w require been sig should b								(2)	Yes 2□No	3 ☐ Prob	ably 4 □Unknown
Vital Records,	e taw re has be	Completed							24a. Was		. Were autop	bsy findings available inpletion of cause of
Ä		mo.								2 No	death?	2. No
ita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?					. Place of Deat	h (Check only o			
of V	Physic this ce al dire	2	1 ☐ Yes 2 No	Hospital:	t 2 ER/Out	patient 3 D	OA Other:	4 ☐ Nursing Ho	me 5 🗆 Resi	dence 6 🗆 C	ther (Specify	")
	ding P. h. After t funera	00::	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day		jury	28c. Injury at Work?		28d. Describe	how injury occ	eurred	
Sio	r Attending er death. rector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not	he -		М		2 🗆 No	ORE Leastion /	Ctropt and Mu		I Cauta Alumba
Division	2 de de c	Certification:	4 Homicide determine		(Specify)	m, street, ractor	у, опісе		City or To		nber or Hura	Route Number,
	spital ours a neral filled		29a. Certifier Certifying F	hysician: To the best of	f my knowledge	death occurred	at the time.	tate and place.	and due to the	cause(s) and	manner as sta	ated.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exe	hysician: To the best of miner: On the basis of and manner stat	examination and	Vor investigation	, in my opinio	on, death occur	red at the time,	date and place	e, and due to	the cause(s)
	vithir To th comp	Me	29b. Signature and title of certifier	4.		29	c. License nu	mber		29d. Date sign	ned (Month, L	Day, Year)
}	0	Y	Dant (elegan	MD		D44.	1088		Aug	LUST	10, 200S
	7		30. Name and address of person who	completed cause of de		Type, Print)	0000	200	1, -	11	(. 1) [21801
	0		David C.	erigen v	10	00 121	eride	B.)	ute 1	1000	0011173	Ny (41)
	Sta		31. Date filed (Month, Aay Gar)	2005 32. R distra	r's Signature	South	.,			r		0

Gertrude O. Brown 218-30-1886

			For 1_ State	State of Maryland	/ Department of H				
			Registrar 1. Decedent's Name (First, Middle, Last)		Oertincate or i	Death	2. Date of Dea	th 2005	4-3. Firms of Death
	Physicia		MARZELL LEE BING	HAM			Month	31 Joos	4:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give st		4b. City, Town, o	r Location of Death		4c. County of Deat	
			Prince Georges	County A	ospital Cher	levly		PGi	
	Funeral		5. Social Security Number 06. Sex	7. Age (In) rs. las	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year) Co	nplace (State or Foreign untry)
	Director		577-62-5542	K- 01	115.		AUG. 2,	1943 WAS	HINGTON, DC
	nand ow		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Many a-1 sh	tor	MARYLAND PRINCE GE	CORGE'S BOW	IE				1 XYes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23e or 28a-f show any injury or other treumetic event, I're Modical Exactified in any injury or other treumetic event, I're Modical Exactified in an once.	by Funeral Director	10e. Street and Number 12611 KEMMERTON LA	ANE	10f. Zip Code 2071	1.5		10g. Citizen of What Co USA	untry?
	ms 23	nera		2. Was Decedent Ever in U.S.	. 13. Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
36	or Ite	y Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A	1 Yes 2 No	Specify:	Hican, etc.)	Black, White Specify:	BLACK
21215-0036	hours turel;	q pa	3X Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a. Decedent's Usual Occup	pation		16b. Kind of Business/	Industry
5	in 72	Completed	(Specify only highest grade		(Give kind of work done life. DO NOT use retired	during most of work	ting		,
212	d with giene.	Com	Elementary/Secondary (0-12) 12TH	College (1-401 5+)	SECURITY G	UARD		DC GOVT	•
pu	tal Hy d othe	Be	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
yla	ould to	10	JAMES DAVIS		19b. Mailing Address (Street		HAWKINS		Zin Codo l
Maryland	nd 2 sh lth and 27 Is m		19a. Informant's Name/Relationship (Typ SHARON HOLDBROOK	e, Print)	10311 BROOM I			20706	up Code)
re,	of Hea item		20a. Method of Disposition	cer	ce of Disposition (Name of metery, crematory or other place	ce)	Date	20c. Location - City or	
imo	Page nent c ent: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	LIN	COLN MEMORIAL	8-9-	05	SUITLAND,	MD
Baltimore,	permit. Departi Importi any inj		21. Signature of Funeral Service License	& Blacks	22. Name and Addre		SHALL'S SUITLANI	FUNERAL HO , MD 2074	
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.	Do not enter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Massive in	tracerepr	al her	norrh	ace	Onset and Death
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ó	an an rial-tr		resulting in death) Last	Due to (or as a conseque	ence of):				
8760,	death certificate be executed attending physician and of for use as the burial-transit	dlcal	d						
9	ertific ling pl	Мес	IF FEMALE:	3c. If yes, outcome of pregnan				001 001 111	
Вох	death certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 Ectopic pregnancy	у		23d. Date of de	overy Day Year
o.	res that the de signed by the a be detached t	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	2 Othor (appeary) _				
s, P	s that the ned by th e detache	by Pi	Part II. Other significant conditions con-	tributing to death but not resul	ting in the underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	-= ° 0	ed k	Hypertension	. ,			1 🗆 Y	'es 3♥No 3□Pr	obably 4 Unknown
000	≥ 1 ° ° ° ·	ompleted	J				24a. Was	sy prior to	itopsy findings available
Ä	The ate h page	Com					perfor 1 ☐ Yes	méed? death? 2MNo 1 ☐ Yes	2 🗆 No
Vital Record	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	occital:	O++	26. Place of Dea	th (Check only o	ne)	
of \	hys this al dir	- To	Yes 2 No	-	H/Outpatient 3 DOA			lence 6 Other (Spe	cify)
	fter ne	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Wo	rk? Yes 2 □ No	200. 2000.00	an injury observed	
Division	al or Atlending s after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (S City or Tox	Street and Number or Ri n. State)	ural Route Number,
Ö	urs after ours after neral Dir	Cert	Tomordo	building, otc. (opeany)					
	Ho Fur Tely	edical		sician: To the best of my know ner: On the basis of examination and manner stated.					
	To the Ho within 24 To the Fu	Me	29b. Signature and title Most title		29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
)			A 44.14	No	Dos	5220		7/3/10	5
K	(1)		30. Name and address of person who co	0 - 101	1.1.	1000	200	Ton	latin M.D.
7			3001 HOSPI TO	Registrar's Signatu	revery h	M) 30	187	. IKELI	4119 1.0.
	St: Regist	ate rar	AUG 0 9 2005	He de la supra des	hadis				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 6, 2005 Year **Physician** Hess Barth 1:00 PM Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury Solomons Nursing Home Solomons Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | Min. | March 14, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 200 Yrs. 91 579-16-8294 Pennsylvania **Director** Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "naturel", or Items 23e or 28a-f show the Medical Examiner must be nutified at Calvert Solomons Maryland 1 Yes XXNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20688 USA 11170 Asbury Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ XXX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other then "naturel", or Ite ury or other treumetic event, the Medical Examina. 1 Never Married 2 Married 1 ☐ Yes ⊋ No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistical Clerk Army Corp of Engineers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thaddeus Hess Emma Elizabeth Rittenhouse 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15275 Hatton Landing Drive Newberg, Maryland Thaddeus Hess III / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or once. Washington Nat. Cemetery Aug. 10, 2005 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses 21. Signatur George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER liver **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 200 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 1 ☐ Yes 2XXNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Cther: Hospital: 1 🗌 Yes ů 2 XX0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel 6 Exactifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier 05 47 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar AUG 0 9 2005

110 Hospital Road #310 Prince Frederick, Maryland 20678

31. Date filed (Month, Day, Year)

Joseph Barth

Charles John Burrell Unpend item#23a,27, permE, 6846,8/24/05 III. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05-05389 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August ďĝ 2005 Charles John Burrell 6:06 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 40 215-78-9300 Yrs. Director Maryland Mar. 16,1965 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f ehov idical Examinar must be notified at 1 Yes 2 No Edgewood Maryland Harford Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21040 USA 4 Maple Avenue Pages 1 and 2 should be filed within 72 hours after death Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 M Divorced 77 is marked other then "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Forklift Mechanic Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Charles Wallace Burrell Ruth Diana Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Burrell - Father 4 Maple Avenue, Edgewood, Maryland item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: if ite any injury or ot once. 1 🔀 Burial Cedar Hill Cemetery 4 Donation ∫5 Dether (Specify) 8/13/2005 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signa 1317 Cokesbury Rd., Abingdon, Maryland and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic cardiovascular disease disease or condition resulting in death) **IMedical** Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Cther (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No funeral director 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ihis 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, Jarm, street, Jactory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by it 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 A medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 10, 2005 Downell, MO person who completed cause of death (Item 23a) (Type, Print) E. Southeril, MD tamela 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) AUG 2 3 2005 32. Registrar's Signature State Registrar

				1 - For State Registrar		State o	f Mary		partment ertificate			Mental Hy	giene Reg. No. ()	0.5	2761	3
		Physici	an	1. Decedent's Name (First		,		0 "				2. Date of De		Year	3. Time of De	eath
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		Examin	ier	Upper Ches	_				Bel A		Location of Dec	auı	Harfo	•		
		Funeral		5. Social Security Number	r 6. Se	∍x		yrs. last birthd			If Under 24 Hi		h	9. Birth	place (State or F	-oreign
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		72 hours after death with the Maryland naturel', or items 23a or 28a-f show alcal Examinet must be positived at	ctor		County Harford		10	c. City, Town of Edg	ewood						10d. Inside City	
		with th	Completed by Funeral Director	10e. Street and Number 2119 Nuttal	Avonu	0			10f. Zip		21040		10g. Citizen o	f What Cou	intry?	
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10	3altimore,			20a. Method of Disposition 1 Burial 2 □ Cree	mation 3 🗌			20b. Place of Di cemetery, o Restlawn				Date 8/21/2005	20c. Location		own, State MD	`
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80	The state of the s	Pnysician /Medical Examiner	ıer	23a. Part I Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedi cause. Enter Underlying Cause (Disease or injury	ire. List only o	a	each line.	onsequence of):				ue: Cumber ac or respiratory a H /M/M		21502	Approximate Interval Betwe Onset and De:	en ath
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newit	ر. ت	es that thighed by be detact	y Pt	Part II. Other significant	conditions co	ontributing to d	eath but n	ot resulting in th	e underlying ca	ause giv	en in Part I.	23e. Did t	obacco use co	ntribute to	the cause of dea	th?
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Ž	OU	ding P h. After funer	tion	1 Natural 5	Pending investigation	28a. Date (Mon	th, Day Ye	28b. Tim lnju	y M	8c. Injur Wor	yat k? Yes 2 ∐No	28d. Describe I	now injury occ	urred		
ff,	Divisi	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		of Injury ing, etc. (5	- At home, farm, Specify)				28f. Location (S City or Tox	Street and Nur vn, State)	nber or Rur	al Route Number	r,
S		To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edicai Ce	29a. Certifier 19 (Check only one)	Certifying Ph	niner: On the b	e best of masis of exa	amination and/o	eath occurred a	at the tin	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and r	nanner as :	stated. to the cause(s)	
		To the within 2 To the comple	Med	29b. Signature and title of	of certifier	Lian	Ala	M	290	Licens	e number	0	29d. Date sign	ned (Month,	Pay, Year)	
		1.		30. Name and address o	person who	completed caus	se of death	n (Item 23a) (Ty	pe, Print)	101	1	110	1.01-	71000	7	
		Sta	ate.	31. Date filed (Month, Da	DION (00 32	3/9 legistrar's	5 BUTH	MIM	1 1	eve !	tul, 14	a L	10/6	5	

Registrar DHMH 17 Rev 1/2001

State

AUG 2 3 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** AUGUST 9:25 PATRICIA ANN CHAMBERS 16, 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LA PLATA

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. CHARLES 11380 DOBBINS LANE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 200 Director 66 577-50-5633 NOV.12,1938 WASH., DC Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location 10b. County ed other than "natural", or Itams 23a or 28a-f show event, the Medical Examinat must be notified at 1 ☐ Yes 2 XNo Director LA PLATA MARYLAND CHARLES 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 11380 DOBBINS LANE 20646 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours after to Popartment of Healin and Mental Hygiene. Toporarist if flam 27 is marked other than "natural; or flamportant: if flam 27 is marked other than "natural; or flamportant in into or other traumatic event, it a Medical Examina 1 Yes 2 No If Yes, Give X Year or Dates: Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2XXVo 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SEARS 11 SALES CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ WILLIAM THOMAS TOWNSEND MARGARET BEACH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 11380 DOBBINS LANE, LA PLATA, MARYLAND20646
ce of Disposition (Name of Date 20c. Location - City or Town, State GEORGE E. CHAMBERS-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition TRINITY MEMORIAL GDNS. 8-22-05 WALDORF MARYLAND 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility MQ0479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 22 No
9 Unknown Day 4 ☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe ³\$₽Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes l or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date liled (Month, Day, Year) 32. egistrar's Signature State AUG 2 3 2005 Registrar

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of M	aryland / D		artmen <i>tificat</i>			and M		iene 2.005	. (27.6	16
	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of Deat Month	h	'ear	3. Time o	of Death
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	Examin	er	4a. Facility Name (If not institution, giv Washington Adven:				4b. City, Takor		Location o	f Death		4c. County of			
	Funeral	- 4	5. Social Security Number 6. 5	Sex 7. Ac		day)			If Under 2	24 Hrs.	8. Date of Birth	Montgo			or Foreign
	Director		250-44-7148	K □M 2□F	ge (In yrs. last birtl 76 Y	rs.	Months	Days	Hours	Min.	June 6, 19	929 (Year)	Cour	place (State ntry)	
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	28a-	rect	10e. Street and Number				10f. Zip	Code			1/	0g. Citizen of Wh	at Cour		
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28s-f show the Medical Examinar must be notified at	by Funeral Director	1815 23rd St. S	SE. # 20	1 – A		20	020				US			
	ems ems	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Deced	lent of His	spanic Orig	gin? (Sp	ecity Yes or No- Rican, etc.)	14. Race -	Amenic White,		
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1X Yes 2 ☐ If Yes, Give			☐ Yes		Specify:	, , , , , , ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ack	
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3	hould d Mer marke metic	To	19a. Informant's Name/Relationship (Mailin	n Addrage	(Street a				City or Town, Sta	err		
e, Maryland 21215-0036	and 2 s		Cecil Davis, Da		181	5	23rd	st.	SE #2	201–2	A Washin	gton DC	200	20	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 271s marked other then "neturel; or Items 23a or 28a-f show any Injury or other treumetic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		20b. Place of cemetery	Dispo: , crem el	sition (Name natory or of Church	ne of ther place 1 Ceme	tery C	8/1	4/05 G	20c. Location - Ci ray Cour	t,	SC.	
Balt	permit. Departr Importe any Inj		21. Signiture of Fundal Service lices	- Palla	on				s of Facility 814 Up		St. NW Was	shington,	DC 2	0011	
			23a. Part1 Enter the disease, or conscious heart failure. List only	lications that cause one cause on each li	d the death. Do no	t ente	er the mode	e of dying	, such as	cardiac o	or respiratory arre	est,		Approxima Interval Bel	
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Box	leath certific attending p I for use as	sian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal death		Ectopic pre					23d. Date of Month		-	Year
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ري ص	igned be deta	by Physician/Me	Part II. Other significant conditions of	ontributing to death b	out not resulting in	he un	iderlying ca	ause give	n in Part I.		23e. Did tob	acco use contribu	ite to th	ne cause of o	death?
ğ	w require been sig should b	led !	1typertensi								1 ☐ Ye	s 2□No 3[Prob	ably 4 🗹	Unknown
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Division of	I or Attence after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		jury - At home, farr tc. (Specify)	n, stre	et, factory	, office			28f. Location (Str. City or Town,	eet and Number of	or Rura	l Route Num	nber,
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1	(d)		30. Name and address of person who	completed cause of c	death (Item 23a) (T 7600 C	ype, F	Print)	Nas Av	p. 7	over To la	tist Ito	Sant E	W.I.	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	912
	Sta	-	31. Date filed (Month, Day, Year)	2. Registr	rar's Signature	•				V. 1	- CTPV 1	NA (C	14,7), <u>"</u>	114
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Registrar

AUG 1 0 2005

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	Physici		Phyllis C.	Eaddy				Month Month	Day (Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Dea		4c. County	of Death	1100
			1133 Snow Hill			Salish			Wicom		
	Funeral Director		5. Social Security Number 6. 212–56–5579	Sex 7. Ag 1 □ M 2 1 58	e (In yrs. last birthda) Yrs.	Months Days		. (Month, Day,			ice (State or Foreign
			Usual Residence of Decedent					5/12/19	4/	Maryl	and
	Maryland -f show	5	10a. State 10b. County		10c. City, Town or I					10	d. Inside City Limits 1 ☐ Yes 2 1 No
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	ith with the Marylar 23e or 28e-f show	ig D	1133 Snow Hill	Road		21804		,	USA	nat Counti	y :
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13		Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race	- America	
36	s after	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 21 ∑ If Yes, Give	No	1 ☐ Yes 2X No		no moun, o.c.)	Specify:	Afri Afri	can
9	thour	ed b	15. Decedent's	Year or Dates: Education	16a. Dec	edent's Usual Occu	upation		6b. Kind of Bus		ican
215	thin 7:	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or t	0+)	e kind of work done DO NOT use retire		orking			,
121	iled wi tygien her th		12 17. Father's Name (First, Middle, Las		Cate	teria Wor		- 15: A 5:-1-15: A		Serv	ice
Maryland 21215-0036	d be featal h	To Be	Samuel Eaddy	51)			Louise	me (First, Middle, M	alden Sumame	a)	
2	shoul nd M	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Stree	at and Number or A	lural Route Number	City or Town, 5	State, Zip C	Code)
ž	and 2 salth a n 27 ls		Ann Murray Grim	n/State Age	ncy 806	f Indepen Snow Hil	dent Liv	ing alisbury,	MD 2180	04	
ore	ges 1 t of He if Iten or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from State	200. Place of Disp	position (Name of ematory or other pla D Memoria	асе)	Date 2	0c. Location - 0	City or Tow	n, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The proporter: If tem 27 is marked other than "neturel", or items 23e or 28e-1 show any injury or other treumatic event. It which a Experiment resulting a ADE.		' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lig		Park		0/		Salisbu		
Ba	Depar Impo any ir		Kell K	aneis (FIB I	followay 01 Snow	Funeral H Hill kd.,	Home Profe Salisbur	essiona,	Asso 21804	ociation
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications hat caused by one cause on each li	the death. Do not er	nter the mode of dy	ring, such as cardia	c or respiratory arre	st,	, A	Approximate nterval Between Onset and Death
	Physician /Medical	8 13	Immediate Cause (Final disease or condition resulting in death)	a. 120	a consequence of):	ance	_				
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):						
•	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
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68	rtificat ng phy as th	Medi	IF FEMALE:	0.							
Вох	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	су		23d. Date Mont	of delivery	ay Year
o.	that the de led by the a detached f	iysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _					uy roa
۵.	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contrit	oute to the	cause of death?
Records,	w require been slg should b							1 □ Yes	2 No 3	B Probab	bly 4 Dunknown
ecc	e law r has be ge 2 sh	Completed						24a. Was an autopsy	pr	or to comp	y findings available Detion of cause of
								perform 1 ☐ Yes 2		ath? ☐Yes 2	□ No
Vital	Physicien: this certificatal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	nt 2 ER/Outpatie	ent 3 DOA Ot	h	ath (Check only one		(0)	
	ig Phy ter this neral o		27. Manner of Death	28a. Date of Inju (Month, Da		MIC OLI DOX	Tudising i	Home 5 Resider			
Sior	r Attending I er death. rector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigati	on	/ rear/ Injury		Yes 2 No				
=	l or Att after d Direct I in by	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury · At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Aural F	Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying F	Physician: To the best aminer: On the basis of	of my knowledge, dea	th occurred at the ti	ime, date and place	e, and due to the car	use(s) and man	ner as stati	ed.
	the H	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.		se number				
	8 7 8 7		Sold and this or entirely	-	30				d. Date signed		y, rear/
•	C		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)	05741	iona E	0 0 1		
	0		100 E. Carro	02, R	lisbury	and.	Sim	Jona E	ng I	0.0.	
	Sta Registr		31. Date filed (Month, AUG 1) 0	2005 32. Registre	ar's Signature	barle					

Thomas Farrar Unpend item#23a, PII 27, 28a-f, perMF, C848, 10/19/05 TT
State of Maryland / Department of Health and Mental Hygiene 05-5513 AKG For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2005 Thomas 2:05 Michael August 1 Farrar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1)☑M 2□F Months 286-42-2582 Director 11/27/1957 Usual Residence of Decedent Manyiand 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location or 28a-f show rthen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 X Yes 2 No **Allegany** Director Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 401 York Place, Apt B 21502 **USA** Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygies Importent: if item 27 is marked other th eny Injury or other treumatic event, IIIs once. Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth McOmber 4 1 1 Farrar Charles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 250 E. Alameda, Apt 418, Santa Fe, New Mexico 87501 Jean E. Farrar / mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/18/2005 Cumberland, Maryland Cumberland Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. ohen 404 Decatur Street, Cumberland, Maryland 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hyperthermia with complications /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit Hospital or Attending Physicien: The law requires thet the death certificate be executed that initiated events the attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Alcoholism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 № Yes 2 □ No 24a. Was an has autopsy performed? certificete 1 Yes 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 2 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ tXOXYes 2 □ No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Page Date of Injury Page 1 Time of PINC Month, Day Year) 28d. Describe how injury occurred subject Certification: 28c. Injury at Work? After 1 Natural
Accident 5 Pending investigation 1∐Yes 2**X**iNo exposed to hot environment 8/14/2005 1:48 P 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 401 York Place 4 - Homicide residence within 24 hours e To the Funersi C completely filled i Cumberland, Maryland 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. August 17, 2005

State Registrar

DHMH 17 Rev 1/2001

2005

THE OPERE MIKE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of the ath (Item 23a) (Type. Print)

111 Penn Street, Baltimore, Maryland 21201 32. gegistrar's Signature

			1 - For State Registrar			nd / Depa		t of H	ealth a		ental Hyg		egibii	.	7020
	Physici	an	Decedent's Name (First, Middle								2. Date of Dea Month		U U U Ye	ar	3. Time of Death
	/Media	al	CLYDE	М.		GINWR:					AUGUST		200		9:14a M
	Examir	er	4a. Fecility Name (If not institution, PRINCE GEOR)	-				Town, or EVER	Location of	Death			County of E		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	لا لا If Under 2	4 Hrs.	8. Date of Birth	1			ORGES
	Director		577-52-6140 Usual Residence of Decedent	1፟፟፟M 2□F	66	Yrs.	Months	Days	Hours	Min.	(Month, Day 3 - 08 -	, Year)	9	Country	ce (State or Foreign
	nyland how		10a, State 10b. County		10c. Cit	ty, Town or Lo	cation							10d	I. Inside City Limits
	Ba-1 s	cto	DC		W	ASHING	TON								Y Yes 2 □ No
	with th	Dire	10e. Street and Number				10f. Zip				1	_	en of What	•	/?
	eath	erai	227 T STREET	I , NE	dent Ever in U	IS 13 V		2000		in? (Spec	cifu Vos or No.		. S . A		ladion
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral Director	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For	ces? 2 (XNo e		f Yes, spec		Specify:	Puerto F	cify Yes or No- Rican, etc.)		Black, V	/hite, etc	2.
Maryland 21215-0036	2 hou atura	ted	15. Decedent	's Education		16a. Deced	tent's Usua	I Occupa	ition				d of Busine		
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ž	hould d Mei mark matic	ပ	GEORGE 19a. Informant's Name/Relationsh		WRIGHT		a Addrona	(Street o	ZAD		MIL Route Number		T 01 .	7: 0	
<u>8</u>	nd 2 s lith an 27 is r trau		FRED GINWRIC		N	4					2A PRI				21000
altimore,	s 1 ar		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of		Da			ation - City		
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a	permit. Departn Imports eny inju		21. Signature of Funeral Service L	icensee /					s of Facility	Т/	3-2005 AYLOR'	S FI	INED	TEN,	OME.
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		e	sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0 9	or as a conseq		AXI	14	TILLI	_					
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9 ×	entifica ding pt	/Mec	IF FEMALE:	220 Hugg outs											
Box	eath certific attending p for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?		ome or pregna th 2 ∐ Feta int at time of d	Ideath 3□	Ectopic pre					23	d. Date of Month	delivery Da	y Year
o.	at the de by the a tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov			Olliei (Spe								
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ğ	w require been sig should b										1 🗆 Ye	s 2 🗆	No 3□	Probabl	y 4 DUnknown
ecords,	e law re has be je 2 sho	Completed									24a. Was ar		24b. Were	autopsy	findings available
\mathbf{r}	Ø □	Com									perform	ned?	death	?	etion of cause of ☐ No
Vital	or Attending Physician: The iffer death. Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	I I a a side la		,		-			Check onl on	-		-	
0	Phys this c	7.	1 ☐ Yes 2 ☑ No 27. Manger of Death			ER/Outpatient 28b. Time of					e 5□Reside			pecify)	
0	ding F h. After funera	tion	1 ☑Natural 5 ☐ Pending		, Day Year)	Injury	M	3c. Injury Work′	at ? es 2.∐No		3d. Describe ho	w injury	occurred		
Division	i or Attendi after death. I Director: A d in by the fu	fica	3 Suicide 6 Could no	ot be 28e. Place of	of Injury - At ho	ome, farm, stre			00 2 0,10		3f. Location (Str	eet and	Number or	Rural Ro	oute Number.
S		Certification:	4 Homicide	building	g, etc. <i>(Specif</i>)	v)					City or Town	, State)			
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1	Physician: To the became the passes and manners	sis of examina	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	a, date and p nion, death	place, an	nd due to the ca	use(s) a ite and p	nd manner lace, and d	as state	d. e cause(s)
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	(n)		· NITT	\$1D			D	57	242			8-	-9-1	25	
)	(1)		30. Name and address of on w	no completed cause	of death (Item	23a) (Type, I	Print)	*	0		CHEVER.		A . >	^	40-
	01		DR KEITH BONIFA 31. Date filed (Month, Day, Year)	20 Ra	distrar's Signa	HDSF ture	IIKL	<i>D</i> 1		(HEVEK.		MD	$\propto 0$	785
	Sta Registra		AUG 1 0 20	05	of death (Item 300) gistrar's Signa	Chan									
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		1	For State Registrar	State of Mary		artment of H tificate of L		ental Hygie Reg.	ne Manns	27621
			Decedent's Name (First, Middle, Last)	-	-			2. Date of Death	Day Yea	-3. Time of Death
	Physicia /Medic		MARY	SYLVIA G	SLOVER			August 8	2005	8.40A M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	,	4c. County of De	eath
			DOCTOR'S HOSPITA	L		LANHAM			PRINCE C	GEORGE'S
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) (hirthplace (State or Foreign Country)
	Director		578-56-3890	70_	Yrs.			JULY 31	1935 WA	SHINGTON, DC
	DG &	-	Usual Residence of Decedent 10a. State 10b. County	100	c. City. Town or Lo	cation	-			10d. Inside City Limits
	anyla sho	5		n crita	IIIIDIID	MARIRODO				1XYes 2 □ No
	the N	Director	MD PRINCE GEO	OKGE 5	UPPER	MARLBORO 10f. Zip Code		10g.	Citizen of What	Country?
	with with		1077 LARGO RD # 41:	2		20774			U.S.A.	
	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f show Te Madical Exprimer , unt to natified at	Funerai		2. Was Decedent Ever	in U.S. 13. \	Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ar	merican Indian,
,	fter deat	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ZNo			in, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.
936	urs a	by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	BLACK
21215-0036	n 72 hours "naturel", adical Exp	ted	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occupa	ation during most of work		. Kind of Busines	ss/Industry
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yla		٦°	WALTER MADDOX				LUCILLE		IALLWOOD	7-0-4-1
	C1 m		19a. Informant's Name/Relationship (Typ				HOUSE LN.	I ADCO M	IARYLAND	20774
di.	jes 1 and 2 t of Health If item 27 I or other tra		LORRAINE SHORTER 20a. Method of Disposition	/DAUGHTER	Ob. Place of Dispo				. Location - City	
Baltimore,	in of h		1 ☐ Burial 2 【ACremation 3 ☐ Re	moval from State	cemetery, crer	natory or other plac				
tim	nit. Pa artmen ortant: injury injury	1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			E CREMATO 2. Name and Addres				, MARYLAND
Bal	permit. Pages 1 Department of H Important: If ite eny injury or ot		21. Signature of Fulleral Service License	1 ~ 0	/			B. JENKI		
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			shock, or heart failure. List only on	use on each line.	^	. \ .				Interval Between Onset and Death
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89	g phys as the	edi							T	
Вох	leath certific attending p	N/U	23b. Was decedent pregnant	Bc. If yes, outcome of p 1 ☐ Live birth 2 ☐		∃Ectopic pregnancy	,		23d. Date of	,
	that the death cer ed by the attendin detached for use	Physician/Me	in the past 12 months?	4☐ Pregnant at time		Other (specify)			Month	Day Year
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	w requires that the been signed by th should be detache	by F	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	inderlying cause giv	en in Part I.	/		to the cause of death?
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000	aw as b	pie						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
Ä	9 4 6	Completed						performed 1 Yes 2 □	death No 1 □ Y	
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Į (Physician: this certific ral director,	To	1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatie			ome 5 Residenc		(pecify)
0	ng PI fter tf inera		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Wor	y at k?	28d. Describe how	injury occurred	
Sio	Attending r death. sctor: After by the fune	catio	2 Accident investigation				Yes 2 □ No			
Division of	after de Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (5	 At home, farm, st Specify) 	reet, factory, office		City or Town, S	t and Number or Itate)	Rural Route Number,
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	Hospitel 4 hours a Funerel i ely filled	edical	(Check only 2 Medical Exemit	ician: To the best of more: On the basis of exa	amination and/or in	ivestigation, in my o	pinion, death occur	red at the time, date	and place, and o	due to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner stated	•	29c. Licens	se number	29d	Date signed (Me	onth, Day, Year)
	with To	_	255. Signature and file VI Contino	E: 1		mo	211.11.0	0	10/0	5
_	(3)					Dries C	016410	8	810	
P	(5)		30 Name and address of person who co	mpleted cause of death	Hanait	on Park	San Sin	La insi	Grant	onth, Day, Year) S 21+, MD 20170
		ate	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	ET TWING	ray, Jule	C/00, (JI ETTI O	-11/1/10/01/10
	اد Regist		AUG 1 0 2005	Marie	K Los	de)				

		-	- State Amend Items Registrar	23b,25,27,	zeland / D 28a-f p	epa er Cer	rtment of Hea ME C848 TO tificate of De	1/04/05 eath	Mental Hy dhb	giene Reg. 2.	005	27622
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Phys /Me	edica	al .	Harold Brent	Garner,	Sr.				Augus	t 5,	2005	12:56P M
Exa	mine	er	4a. Facility Name (If not institution, give	•			4b. City, Town, or Loc	cation of Deat	h		County of Death	
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Funei Direct	_		5219-16-1468 6. S	M 2□F		rs.		lours Min.		ау, Year) [6.]	L926	MD
pu 💃			Usual Residence of Decedent		10a Cit. Taur		4					
laryla shov		_	MD 10b. County Char1	es	LaP1							10d, Inside City Limits 1 ☐ Yes 2 No
the N 28a-f		ect	10e. Street and Number				10f. Zip Code		Т	10a Citiz	en of What Cou	
3a or			8710 Port Toba	cco Rd.			2064	6			USA	
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland not Mental Hygiene. I marked other then "naturel", or Items 23e or 28e-f show unalice event, the Medical Examinal mental be publised at		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? Types 2 D If Yes, Give Year or Dates:	o		Vas Decedent of Hispa Yes, specify Cuban, N ☐ Yes 2 (25No S	nic Origin? (S Mexican, Puer Specify:	pecify Yes or Note Rican, etc.)	1	4. Race - Ameri Black, White, Specify: Wh	
2 hou ature		ed	15. Decedent's Ed	lucation	7/31/64	6 eced	ent's Usual Occupation	n		16b. Kin	id of Business/In	dustry
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shoul and Me s mark		e .	19a. Informant's Name/Relationship (19b.	Mailin	g Address (Street and Port Tob					Code)
Tand 2 Health a		-	Shirley M. Garn	er/Spous				acco				
Pages nent of ant: If it			20a. Method of Disposition 1	<i>'</i>)	cemeters	d F	ition (Name of atory or other place) Ieart Cem	1	·	LaP	ation - City or To	
permit. Departr	once		21. Signature of Funeral Service Licer	Ely M	00945	P.	EHARTTEC O. Box 5	<u>67 La</u>	Plata,	MD_2	ME,PA 0646	
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The law requires that the death certifications is the law requires that the death certifications are been signed by the attending page 2 should be detached for use as		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				3d. Date of delive Month	ery Day Year
quires that n signed build be deta	Ι.	2	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the un	derlying cause given in	Part I.		tobacco us Yes 2 🗆		ne cause of death?
The law require ate has been signage 2 should b		Completed	Sardin and	lyttua			Cardin	yogat		psy ormed?	prior to co death?	psy findings available mpletion of cause of
	- 1	a	25. Was case referred to medical	THE Y WELL			26	. Place of Dea	TI ☐ Yes ath (Check only o	2 No	1 🗆 Yes	2LJ N0
nysician: nis certific director,		0	examiner? TX Yes 25 No	Hospital: 1 Inpatier	nt 2 ER/Out	patient	Other				Other (Specif	y)
nding Ph ath. r: After th	,		27. Manner of Death 1 □ Natural 5 □ Pending 2 Accident investigation	28a. Date of Injun (Month, Day 08/05/20	799ar) 28b. Ti	jury	28c. Injury at Work? M 1 ☐ Yes	2 📆 No	Food bo			ing airway
or Atte Ifter de Directo		rtific	3 Suicide 6 Could not be determined	building, etc	(Specify)	m, stre	et, factory, office		City or To	wn, State)	LaP1	A Route Number,
To the Hospitel or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funaral director,		edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner state	f my knowledge, examination and	death Vor inv	occurred at the time, destigation, in my opinion	date and place on, death occu	, and due to the tred at the time,	cause(s) a	ta Rd.,R	Room 323A
To the within To the	:		29b. Signature and title of certifier	2 1			29c. License nu	mber		29d. Date	signed (Month,	Day, Year)
			In	1/ Jule	MA		1200	010	90	8	3-5-09	2
381			30. Name and address of person who Henry L. Burke, I	4D 115-A La	a Grange			ıta, Ma	ryland	20646		
Regi	Stat istra		31. Date filed (Month, Day, Year) AUG 0 9 2005	32. Registra	r's Signature							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** JOHN AM BRENDEN HERDEGEN JUL 28 2005 1:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1XM 2□F Months Yrs. N/ADirector July 27, 2005 | Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

97 27 Is marked other then "natural", or Items 23e or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, If a Madical Examiner hast be notified at 1 Yes 2X No Director Virginia Stafford Stafford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Alf Lane 22556 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify: Specify: White δ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dale W. Herdegen Teresa Ann Gunderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other trau <u>once</u>. Dale W. Herdegen (Father) 11 Alf Lane Stafford, Virginia 22556 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cem, 8/1/05 Triangle, Virginia 21. Signature 22. Name and Address of Facility 4143 Dale Blvd. Mountcastle Funeral Home Dale City, VA 22193 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TRISOMY 13 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 💢 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Cther: 1X Inpatient 2 ☐ ER/Outpatient P 1 Tes 2X No After this c 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 July 29, 200 5 Sarah L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER CPT SARAH L.-BROWN MC USA BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year AUG 2 State 2005 Registrar

		1 - For State Registrar	State of Ma	ryland	•		nt of H te of L		and M		Reg. No.	005	27624
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) FRANK 4a. Facility Name (If not institution, give s	E street and number)	HOLI	LEY	4b. City	, Town, or	Location of	of Death	2. Date of De Month AUGUS	Day ST 8	Yes 2005 County of D	6:30A
Funeral Director	Ç.	3/8-32-1611			st birthday) Yrs.		DELPH er 1 Year Days	II If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, Di May 2	rth ay, Year)	9. 1	E GEORGE † S Birthplace (State or Fore Country) ryland
3e-f show tiffed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince G			Town or Lo		oro						10d. Inside City Lim 1⊠Yes 2□
naturel', or Items 23a or 28e-f show dical Examinst must be rectified at	Funeral Director	10405 Rambling Hi		er in II C	12.1	207			-:-0 (0		U	S.A.	
rel', or Item Examination	þ	11. Marital Status 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	 12. Was Decedent Evarued Forces? 1 ☐ Yes 2 ☑ Note of the Pear or Dates: 			f Yes, sp	edent of Hi ecify Cuba 2 1 No	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		A. Hace - A Black, W Specify:	merican Indian, hite, etc. Black
jiene. r than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			16a. Deced (Give life.	kind of w DO NOT	ual Occupa ork done d use retired,	luring mosi)	t of worki	ng		d of Busine	,
n' of Health and Mantal Hygiene. : If item 27 is marked other than "naturel", or Items 23a or 28e-1 show or other treumetic event, the Medical Examinations Le rotified at	To Be C	17. Father's Name (First, Middle, Last) Robert Holley	0					Lou	iise	(First, Middle	her		
of Health and item 27 is n r other treun		19a. Informant's Name/Relationship (Type Annie M. Holley/) 20a. Method of Disposition	Wife	20b. Pla		5 Rat	mblin	g Hil	ll Ct		r_Mar	1boro	o, ^{Zip Code)} 20773 • Mary 1 and or Town, State
Department of H Importent: If ite any injury or ot once.		1 Maurial 2 □ Cremation 3 □ R 4 □ Donation □ Other (Specify) 21. Signature of the rate Service License	emoval from State		OLIV 22	ET C	EMETE	RY 8		B. JE	NKINS		RAL HOME
nysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the cause on each line).	Do not ent							MARYL.	AND 20785 Approximate Interval Between Onset and Death
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attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	3c. If yes, outcome of 1□Live birth 2	f pregnand	cy death 3	Ectopic	pregnancy				23	3d. Date of of Month	delivery Day Year
ign e d by th be detache	by	9 Unknown Part II. Other significant conditions con	9□ Unknown tributing to death but	not result	ting in the u	nderlying	cause give	en in Part I.			obacco us		to the cause of death?
has been ge 2 shouk	Completed							-		24a. Was	an	24b. Were	autopsy findings availa o completion of cause o
r this certific ral director,	To Be	27. Manner of Death	ospital: 1 Inpatient 28a. Date of Injury (Month, Day)	. 2	R/Outpatien		Othe 28c. Injury Work	or: 4√⊋Nu	rsing Hor	(Check only one 5 ☐ Resi	one) dence 6	□Other (S	A
after death. Director: After	Certification:	1 Danatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	y - At hom		M eet, facto	1 🗆 \	res 2□l	-	28f. Location (City or To		Number or	Rural Route Number,
within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of ner: On the basis of e and manner state	examinatio	ledge, death on and/or in	occurre vestigatio	of at the tim n, in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner place, and d	as stated. ue to the cause(s)
within 2 To the complete	W	29b. Signature and title of certifier	les		MD		oc. License	number	82	90	29d. Date	signed (Mo	nth, Day, Year)
Sta Registr		30. Name and address of person who concentrated the sureshkumar Must also be sureshkumar Must al	ttah M.D. 2. Registrar	4203 's Signatu	Quee	nsbu	ry Rd	. Нуа	ittsv	ille,	Maryl	and	20781

			For State	State of Marylar	ıd / Depar	tment of H	leaith and N	Mental Hygie	•	
	0		State Registrar 1. Decedent's Name (First, Middle, L.	ast)	Certi	ificate of I	Deam	2. Date of Death	No. 0 0 5	3. Time of Death
	Physici /Medio	al	Turhan			Jon	<i>es</i>	August	Day Year	5 12:00 PM
	Examin	er	4a. Facility Name (If not institution, gi	Hopkins Ho		Baltin	Location of Death	City	4c. County of Death	
	Funeral Director			Sex 7. Age (<i>In yrs</i> . 25	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You October 22,	9. Birth Cou 1979 Washir	place (State or Foreign intry) ngton, DC
	tryland thow		10a. State 10b. County		y, Town or Loca attsvi					10d. Inside City Limits
	the Ma 28a-f s	Director	10e. Street and Number	deorge 5 my	accsvi	10f. Zip Code		100	. Citizen of What Cou	1 🕍 es 2 □ No
	er death with the Marylan Items 23e or 28a-f show Nermust be modified at		5604 Cypress C	reek Dr. # 3	02	2078	2		USA	
920	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show Ite Medical Examinar must be indiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Y	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White, Specify: B1	etc.
21215-0036	be filed within 72 hours afte tal Hygiene. d other than "naturel", or I event, the Medical Examit	Completed	15. Decedent's to (Specify only highest green terms) (Specify only highest green terms) (Secondary (0-12)	Education rade completed) College (1-4or 5+) 3+	(Give kii life. DC	nt's Usual Occup nd of work done of NOT use retired	ation during most of work t)	sing 161	Education	ŕ
Maryland	hould be filed id Mental Hygie marked other matic event, II	To Be C	17. Father's Name (First, Middle, Las Turhan	Jones	Sr		18. Mother's Nam Debbi	e (First, Middle, Mai	White	
	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship Debbie White,					nire, IL 600	ity or Town, State, Zip 169	code)
Baltimore,	Pages 1 and nent of Healt int: If item 2: iry or other		20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Ponation 5 Other (Special Control of Control	- nemovarmom state	Place of Disposition	ion (Name of tory or other place Cemetery	08/18,	Date 200 705 Cir.	c. Location - City or To Cinnati, CH.	own, State
Balti	perrit. Pag Department Importent: I any njury o		21. Signature of Funger Service Too	- Pallisa		Name and Addres	,	St. NW Wash	nington, DC 2	20011
	be executed / Medical Examiner purial-transit	l Examiner	23a. Par I. Enter the disease, or construct, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) C. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of the	Sacter,	g, such as cardiac	or respiratory arrest,	15 6	Approximate Interval Between Onset and Death
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ls, P.0	res that the de signed by the i be detached	by	9 ☐ Unknown Part II. Other significant conditions	9□ Unknown contributing to death but not res	ulting in the und	erlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
al Records,		e Completed						24a. Was an autopsy performed	24b. Were auto prior to co death?	ppsy findings available impletion of cause of
Division of Vital	Attending Physer death. ector: After thiseby the funeral dis	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Matural 5 Pending investigating i	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury ome, farm, stree y)	28c. Injury Work	er: 4 Nursing Ho	28d. Describe how i	t and Number or Rura	
_	To the Hospital or within 24 hours after the Funeral Discompletely filled in	edical C	one)	rhysician: To the best of my knominer: On the basis of examina and manner stated.	wiedge, death o tion and/or inves	occurred at the tim stigation, in my of	ne, date and place, pinion, death occur	and due to the causered at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	vithi Vithi Comi	Σ	29b. Signature and title of certifier	manin !	M.D.	29c. License	number 5-00	20 Ac	Date signed (Month,	Day, Year) 7, 2005
R	(2)		30. Name and address of person who	completed cause of death (Item	23a) (Type, Pri	int) ///// 1/	TH WHE	Steet, Butti	mare Mary	m/2/1787
:	Sta Registr		31. Date filed (Month, Day, ear) AUG 1 0 200	32. Registrar's Signa	ture	ey. W.	IN WIE	escerell)	TOLOS /10	-10 5/20

			For State Registrar	State of M	arylan		rtment <i>tificate</i>			and Me	ental Hyg		ing stone	07404
	Physici /Medic		Decedent's Name (First, Middle, La	Velma K	ay1or	Hearn					2. Date of Dea Month August	8, Day 200!	Year	7:00 A. M
	Examin		4a. Facility Name (If not institution, giv 16408 Banbury La	ne			В	owie				4c. County Princ	ce G	eorges
Tar.	Funeral Director		5. Social Security Number 6. S 258-54-1773 Usual Residence of Decedent	ex 7. A	93	Yrs.	If Under 1 Months	Days	If Under a	Min.	B. Date of Birth (Month, Day Mar. 28	, 1912	9. Birti Co A1:	nplace (State or Foreign untry) abama
	Maryland I-f show	tor	10a. State 10b. County Md. Prince G	eorges	10c. City	y, Town or Lo	cation	В	owie					10d. Inside City Limits 1 🛣Yes 2 □ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 16408 Banbury La	ne			10f. Zip (0715		1	0g. Citizen of V	What Co	untry?
036	ours atter dea al', or Items Exeruther m	by	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 A If Yes, Give Year or Dates:	?	H	Vas Decede Yes, speci		spanic Origin, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	Blac	e - Americk, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours alter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s or 28a-f show any injury or other traumatic event, Ite Medical Examinational Letteridited all once.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)		ent's Usual kind of work OO NOT use memak	k done di e retired)	tion uring most	of working	9	Own he		ndustry
yland	ould be file Mental Hy arked othe	To Be C	17. Father's Name (First, Middle, Last,	rlie Eddi	e Kay	lor			18. Mother			Maiden Suman Leona Lo		y
, Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Martha Jo Schupp			16408	Banb	ury				yland 2		
Baltimore,	Pages 1 ment of H tant: If iter		20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 X 4 □ Donation 5 □ Other (Specif		CE	lace of Disposemetery, cremetery, Co	atory or oth	her place			-05		on,	rown, State Georgia
Ball	permit Depart Import any in		21. Signature of Funeral Service Licer	IN VE	Zal	6		.W.	Crain	1 Hwy	., Bowi	eral Ho e, Mary		1 20715
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each i	c arr	hythmi		of dying	, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death 1 day
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8760,	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):								-
Vital Records, P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic pred Other (spec					23d. Dat Mo		very Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions of Dementi		out not resu	ilting in the un	derlying ca	use give	n in Part !.					the cause of death?
al Reco		Completed								_	24a. Was a autops perform	y ned?	rior to co leath?	opsy findings available ompletion of cause of
	Physician: The this certificate har all director, page	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	ER/Outpatient	3 DOA	Othor	~	•	Check only on 5 □ Reside	e) ince 6 🗆 Othe	er (Spec	fy)
Division of	r Attending Ph er death. rector: After th by the funeral	atlon:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry ly Year)	28b. Time of Injury	28 M	c. Injury Work		28		w injury occurr		***
Divis	2 4 5 5	Certification:	3 Suicide 6 Could not be determined	286. Place of In	jury - At hoi c. (Specify	me, farm, stre	et, factory,	office		28	f. Location (St. City or Town	reet and Numb , State)	er or Rur	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis o and manner st	f examinati	vledge, death ion and/or inv	occurred at estigation, i	t the time n my opi	e, date and nion, death	l place, an n occurred	d due to the ca at the time, da	luse(s) and ma ate and place, a	nner as : and due !	stated. to the cause(s)
^	To the within 2 To the Complet	Me	29b. Signature and title of pertiller	200	20			License				od. Date signed August		
R	(2)		30. Name and address of person who Sankineni J. Ra					Rd.	, #22	О, Во				
	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) AUG 1 0 200	Registr	ar's Signat									

			- For 8-11-05 Registrar Amend#'s 8.18.		aryland / Dep <i>Ce</i>	artment of F			giene Reg. NO 1 1 5	27527
>	Physici /Medic		Decedent's Name (First, Middle, Last) William Thomas Ha	wkins Jr				July 29	Day Year	14:51 PM
	Examin	er	4a. Facility Name (If not institution, give s Prince George's Ho	spital C		Chever1			4c. County of De Prince Ge	eorge
	Funeral Director		10 2013	tM 2□F 3	9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. B 165 12-19 DC	irthplace (State or Foreign Country)
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State DC N/A		10c. City, Town or L Washing to					10d. Inside City Limits 1 Yes 2 No
	h with the	al Direc	10e. Street and Number 6226 Banks P1 N. F			10f. Zip Code 20019			10g. Citizen of What C	Country?
920	be filed within 72 hours after death with the Maryland tat Hygiene. Id other than "natural", or liems 23a or 28a-f show other than "natural", or liems 23a or 28a-f show event. I'r. Medical Exaff in crinital be rediffed at	by Funeral Director	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 (X) If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☑ Yes 2☐ No		Specify Yes or No rto Rican, etc.)	14. Race - An Black, Wh SpecifyBla	
Maryland 21215-0036	within 72 ho lene. 'than "natur'	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	(Give life.	dent's Usual Occup b kind of work done DO NOT use retired rt Order	during most of wo d)	orking	16b. Kind of Busines	s/Industry
yland 2	should be filed nd Mental Hygi marked othar umatic evant. I	To Be C	17. Father's Name (First, Middle, Last) William T. Hawkir				18. Mother's Na Faye I Faye Ha	ayton Harrison H	awkins	
	1 and 2 s Health ar sm 27 is ther trau		19a. Informant's Name/Relationship (Ty Faye Hawkins Faye Harrison Hawk 20a. Method of Disposition	ins	6226	Banks P1	NE, Was		DC 20019 20c. Location · City of Brentwood,	or Town, State
Baltimore,	permit. Pages Department of I Important: If itt any injury or o once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Loens	hen-	1/ // // .		ss of Facility ${f D}$.		ighlin's Fu on DC 2000	neral Svc Inc 12
	ficate be executed / Medical Examiner is the burial-transit	Examiner	23a. Part1. Enter the disease, or domplishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as Due to for as Hypen	io Pulmuna a consequence of): Stage Rena a consequence of): tension a consequence of):	ry Arrest		co or respiratory a	rrest,	Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and oags 2 should be detached for use as the burial-transit	Physiclan/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome	2 Fetal death 3	y Disease □Ectopic pregnance □ Other (specify)			23d. Date of d Month	lelivery Day Year
Ω.	n requires that i been signed by should be deta	by	Part II. Other significent conditions cor	ntributing to death b	out not resulting in the a	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 □Unknown
al Records,		Completed						24a. Was auton perfo 1 □ Yes		
on of Vital	Attanding Physician: Th r death. actor: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes No	Iospital: 1 Inpatie 28a. Date of Inju (Month, Da		of 28c. Injur	ner: 4 Nursing		one) dence 6 Other (Sp how injury occurred	necify)
Division	al or Attandii s after death. Il Diractor: A sd in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	jury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (. City or Tot	Street and Number or I vn, State)	Rural Route Number,
	To tha Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	edical	(Check only 2 Medical Examione)	sician: To the best ner: On the basis o and manner st	of my knowledge, dea of examination and/or in ated.	th occurred at the time time the time t	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manner added and place, and de	as stated. ue to the cause(s)
	To tha within 2 To tha complet	M	29b. Signature and title of certifier	1 May	de ms	29c. Licens	30 number	92	29d. Date signed (Mol	1th, Day, Year)
R	(F)	-	30. Name and address of person who co	106 Irvi	ng St N.E.	South To	wer #204	, Washin	gton DC 20	011
	Sta Regist		31. Case filed (Month, Day, Year) AUG 0 9 2005	Registr	rar's Signature	Le				

Physicia /Medica Examine

Funeral Director

Please	State of	Marylan	d / Den	artment of I	Health	and M	lental Hv	alene	e		
1 - For State Registrar	Olato Ol	····a· y (a)		ertificate of				Reg. No	000		27620
Decedent's Name (First, Middle, La	ist)						2. Date of De	ath	- 00		3ne of Death
Violet Diane Jac	ckson						Month August	Q Da	2005	/ear	12:25 Å
4a. Facility Name (If not institution, giv		iber)		4b. City, Town,	or Location		August		. County of		12.23 A
Woodside Nursing	Center			Silver	Spri	ng		М	ontgo	merv	,
5. Social Security Number 6. S	Sex	7. Age (In yrs.	last birthday		If Under		8. Date of Bir (Month, Da	th			lace (State or Foreign
	1□M 2€F	91	Yrs.	Wortins	riours				1914	Nels	son Co. VA
Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y. Town or L	ocation						10	Od. Inside City Limits
DC			ingto								1 A Yes 2 □ No
10e. Street and Number				10f. Zip Code				10g. Ci	itizen of Wh	at Count	try?
1924 Varnum str				20018					ited		
11. Marital Status	12. Was Dece	ces?	S. 13.	. Was Decedent of I If Yes, specify Cub	Hispanic Or ban, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black,	America White, e	
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes If Yes, Give Year or Da	Э		1 ☐ Yes 2 🛣 No	Specify	:			Specify:	B1a	ıck
15. Decedent's E (Specify only highest gra			(Giv	edent's Usual Occu e kind of work done	during mos	st of work	ing	16b. K	Kind of Busin	ness/Ind	lustry
Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retire	ed) -		-		Domes	tic	
5th 17. Father's Name (First, Middle, Last,					10 Moth	or's Name	e (First, Middle,				
Charlie Johnson						Dobb		iviaidei	r Sumame)		
19a. Informant's Name/Relationship (Conrad Butler (1				ling Address (Street Laurel 1			man, VA			ate, Zip	Code)
20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from S		emetery, cre	position (Name of ematory or other place oln Ceme)	rce)	-	2/2005	20c. L	ocation - Ci	_	
*4 □Donation 5 □Other (Specif	(V)			OIN CUIC			, 2003				
21 Signature of Euperal Service Lines					-	-				7 77	
21. Signature of Funeral Service Licental			2	22. Name and Addre	ess of Facil	Fort	Linco	ln F	unera od, M		
21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that car one cause on ea	uused the death ich line. psis or as a consequ	340 n. Do not er	22. Name and Addre	ess of Facil	Fort Road	Lincol Bren	ln F n tw o		D 20	
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State Registrar

S.K. Gupta, M.D.

31. Date filed (Month, Day, Year)

AUG 1 0 2005 DHMH 17 Rev 1/2001

9801 Georgia Ave Suite 220 32. Registrar's Signature

Silver Spring, MD 20902

			1 - State o	of Maryland / Depa	artment of Heali		al Hygiene	005	27620
	Physici		1. Decedent's Name (First, Middle, Last) OI, From JAVCOH				ate of Death onth Day	5 Year	3. time of Death 230 PM
	/Medi Examir		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Local	ation of Death		County of Death	
			5. Social Security Number 6. Sex.	LAKE	SAIS MM M If Under 1 Year If Un	nder 24 Hrs. 8. Da		100 Mice	
	Funeral Director		5. Social Security Number 2193666	7. Age (In yrs. last birthday) U 2 Yrs.		ours Min. (M	ate of Birth fonth, Day, Year)	Count	ace (State or Foreign ry) 7land
	ryland thow		10a. State 10b. County	10c. City, Town or Lo	ocation			10	d. Inside City Limits
	8a-f	Funeral Director	Maryland Worcester	Bishopvil					1 ☐ Yes 2X No
	with t	Dir	106. Street and Number 10648 Piney Island Driv	~	10f. Zip Code 21813			zen of What Count	ry?
	death ma 23	nera	11. Marital Status 12. Was Dec		Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Y		JSA 4. Race - America	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 Ia marked other than "natural", or Itema 23a or 28a-1 show or other traumatic event, the Medical Evartinar must be notified at	by	Armed For 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year or D	2X No ve		ecify:		Black, White, e Specify: Wh	ite
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kir	nd of Business/Ind	ustry
2121	filed within Hygiene. Ither than "	Jupl	Elementary/Secondary (0-12) College (1-4or 5+) Acto			Pro 4		
d 2	2 should be filed within and Mental Hygiene. Ia marked other than aumatic evant, the Me	Be C	17. Father's Name (First, Middle, Last)	7.000		Mother's Name (First		certainme Sumame)	ent
ylar	should be find Mental I	To E	Clifford Jarrett Sr.		Cl	hristine V	/iola Far	mer	
Maryland	12 sho		19a. Informant's Name/Relationship (Type, Print) Bob Richmond/cousin		ng Address (Street and No				Code)
	permit. Pages 1 and. Department of Health Important: If Item 27 any injury or othar tr once.		20a. Method of Disposition	20b. Place of Dispo	8 Abell Ave.	., Baltimo		21218 cation - City or Tov	vn. State
Ö	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 1 ☐ Donation 5 ☐ Other (Specify)	State	y Crematory	8/8/200	15	lisbury,	
Baltimore,	permit. Par Departmen Important: any injury		21. Signature of Funeral Service Licensee	22	Name and Address of F	acility			
	Dep name		23a. Part. Entre disease, or complications that of the part of the	my CFSP 5	01 Snow Hill	l Rd., Sal	Proiessi isbury,	onal Ass MD 21804	ociation
8760,	Physician /Medical Examiner popularitansit physician and	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of): CFPHM (or as a consequence of). 1ALNUTTE 17 (or as a consequence of):	PATHY -	CER -			Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		2	3d. Date of deliver	y Day Year
ds, P.	signed to be det	by	Part II. Other significant conditions contributing to de	eath but not resulting in the un	nderlying cause given in P			se contribute to the	cause of death?
COL	w requires been sistemed to should the	lete	CANCER.		7.		ta. Was an		sy findings available
of Vital Records,		e Completed	25. Was case referred to medical				autopsy performed? Yes No	prior to com death?	pletion of cause of
Ι	ys dir	To B	examiner?	Inpatient 2 ER/Outpatien	0.5	Place of Death (Chec Nursing Home 5		Other (Specify)	
	ding Ph h. After th funeral		27. Manner of Death 28a. Date				escribe how injury		
Division	Atten r deat sctor: y the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, str ng, etc. (Specify)	M 1 ☐ Yes :	28f. Lo	cation (Street and ty or Town, State)	Number or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funaral Director completely filled in the	edical (29a. Certifier (Check only one) Certifying Physician: To the beand maniner: On the beand maniner.	best of my knowledge, death asis of examination and/or inv ner stated.	h occurred at the time, dat vestigation, in my opinion,	te and place, and du , death occurred at th	e to the cause(s) ane time, date and p	and manner as sta place, and due to t	ted. he cause(s)
	To th withir To th comp	-	29b. Signature and title of certifier		29c. License numb	ber	29d. Date	signed (Month, D	ay, Year)
)	2		Janen a 29	acce-	D1456	56		816105	
	100		30. Name and address of person who completed caus AMES W. ISAACS 31. Date filed (Month, Aug Coa) 32. B	e of death (Item 23a) (Type,	Print)	1216174	35/140	218c	PIPE 1245
F	Sta Registr	te ar	31. Date filed (Month, AUGT) 0 2005	Jistrar's Signature	harle		,		

			1 - State Registrar	State of M	laryland /	•	artment rtificate			ınd Me		giene Reg. NQ (105	27620
	Physici	an	Decedent's Name (First, Middle, Last Pear		G.		Johns	on			2. Date of De Month Igust 4,	Day	Year	3ne of Death 10:43 A M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number					_ocation or		igust 4,	4c. Co	ounty of Death	1
	Funeral		Southern Maryland Hos 5. Social Security Number 6. Se		ge (In yrs. last b	irthday)	Clint If Under	1 Year	If Under 2	24 Hrs. 8	Date of Birl		nce Geor	nplace (State or Foreign
b	Director		5/8-30-3/48	M 2K2K	95	Yrs.	Months	Days	Hours	Min.	Month, Da pril 20	, 1910	Co	uryland
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation					<u>-</u>		10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland Prince Geo	orge's	Oxon 1	Hill	10f. Zip	Code				10a Citizer	n of What Co	1 ☐ Yes 2XXNo
	th with	ai Dir	6610 Livingston Road				TOI. ZIP	2074	5			US		unitry :
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinating the notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Tes 2 Tes 1f Yes, Give Year or Dates:	? ‱		Was Deced f Yes, spec 1 Yes 2	ify Cuban	panic Orig , Mexican, Specify:	jin? (Speci , Puerto Ri	fy Yes or No can, etc.)		Race - Amer Black, White	
Maryland 21215-0036	n 72 hou	pieted	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	dent's Usua kind of wor DO NOT us	k done du	ion uring most	of working	1	16b. Kind	of Business/I	ndustry
212	ed with /giene. lar thar t, the M	Comp	Elementary/Secondary (0-12) 7th	College (1-4or	5+)	Но	nnemake						n Home	
and	id ba fill ental Hy kad oth c evan	To Be	17. Father's Name (First, Middle, Last) Eugene L. Sanders							,	First, Middle, Skinne		mame)	
lary	2 shoul and Me le mar! aumati	Ĕ	19a. Informant's Name/Relationship (T)	rpe, Print)	19	b. Mailir	ng Address	(Street ar	nd Number	r or Rural I	Route Numbe	er, City or To	own, State, Z	ip Code)
	1 and Health tem 27 othar tr		Gordon Johnson / Son 20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of		hesvil Da	le, Mar		20637 tion - City or 1	Γown, State
Baltimore,	Pages ment of I ant: If its ury or o		NXXBurial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Ft. Li		natory`or of 1. Cemet			gust 9	, 2005	Brentwo	ood, Mar	yland
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or othar tra 90.09.		21. Signature of Funeral Septice Licens	b		1	6160 0			GEOI	ge P. K n Hill,			lome P.A. 1745
			23a. Party. Enter the disease, of comp show, or heart failure. List only o Immediate Cause (Final	ications that cause ne cause on each	d the death. Do	not ent	er the mode	of dying	+		1			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or a	s a consequence	9 of):	4	CKI	·leri	4 (7128	150	•	
		ner	if any, leading to immediate	Due to (or a	s a consequence	of):								
	executed and al-transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence	of):							-	
8760,	cate be executed physicien and the burial-transit	dicai		d										
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 Fetal deat at time of death		Ectopic pre Other (spe					23d	l. Date of deli Month	ve ry Day Year
rds, P.	quires that n signed bi uld be deta	b	Part II. Dther significant conditions co	ntributing to death	but not resulting	in the u	nderlying ca	tuse giver	n in Part I.			obacco use (es 2/27)		the cause of death?
Division of Vital Records,		Completed									24a. Was autop perfo 1 Yes		t4b. Were aut prior to c death?	opsy findings available ompletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	_		Check only o			
ion of	Attending Physician: r death. sctor: After this certificator, by the funeral director.	ation; To	1 Yes 2 No ' 27. Manner of Death 1 NNatural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ient 2 ☐ ER/O ury ay Year) 28b.	Time of Injury		3c. Injury	at I I I I	28	5 ☐ Resid d. Describe h		Other (Spec	ify)
Divis	E E te	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir building, e	njury - At home, f tc. <i>(Specify)</i>	farm, str	eet, factory	office		28	f. Location (S City or Tov		lumber or Rui	ral Route Number,
	To tha Hospital within 24 hours a To tha Funaral Completely filled	edicai	29a. Certifier (Check only one) 1XX Certifying Phy 2 Medical Exami		of examination a									
1	To tha within 2 To tha complet	Me	29b. Signature and title of sertifier		44.0		29c.	License DO05	number 52999				igned (Month	
	(15)		30. Name and address of person who co		death (Item 23a)							_		
	Sta	te.	Ali Rahimian 31. Date filed (Month, Day, Year)		7501 Sur trar's Signature	rat	ts Roa	ad #	#205	Clint	on, Ma	arylan	d 207	'35
	Registr		AUG 0 9 2005		K	hand	80							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 2335 William Thomas Kettlebar August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center: Bel Air Harford 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) Feb. 20, 1910 Indiana If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1⊠M 2□F 95 104-05-8663 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Harford 1XXYes 2 □ No Director Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive Apt. 311 21014 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours atter l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel any injury or other traumatic event, the Middial Extention once. 12 Yes 2 No
If Yes, Give
Year or Dates: 1924-31 1 Never Married 2 Married 1 Yes 28 No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Gleason Works Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Kettlebar Lulu Adair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Martin (Step-son) 112 Wheaton Drive, Littlestown, PA 17340 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 8/18/05 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State Naples, New York ' 4 ☐ Donation 5 ☐ Other (Specify) Italy Naples County Line Signature of Funeral Service Licensee 22 Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart Congestive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of). the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) tor: After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Rena tailure. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural Injury death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32255 August 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MacPhail Road M.D. 615 W. 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

homas

Kettlebar, William

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Stephen Jeffery Koch 2005 August 8. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 (**X**M 2 □ F Director 412-72-1645 Yrs 59 24, 1946 Illinois Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Md. Prince Georges 1K Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Items 23e 2704 Birdseye Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.

is marked other than "natural", or Iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 A No þ Specify: 3 AWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Joseph Koch Hazel Henderson ္က 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Dietrich - daughter 203 17th Ave., Brooklyn Park, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 08-12-05 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Metropolitan Crematory ^¹ 4 □ Donation 5 □ Other (Specify) Alexandria, VA. 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 0((6 **Physician** disease or condition resulting in death) U /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical ası IF FEMALE nse : 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 1 ☐ Yes 2 ☐ No 9□ Unknown 9 🗌 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No certificate 1 🗌 Yes the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ٥ Other: 1 ☐ Yes 2 ☐ Ño 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. s after death 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide filled in 24 hours a 29a. Certifier -Certifying Physioran: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature an 29d. Date signed [Month, Day, Year) 30. Name and address of person no completed eause of death (Item 23a) (Type. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 1 0 2005 Registrar

		1 - For State Registrar		e of Marylar			nt of H		and M	lental Hy	Reg. No	005	27.634
Physici	ian	Decedent's Name (First, Middle BEATRICE	, Last)	,	LONG					AUGUST	Da 5	2005	11:29 PM
/Medi Examir		4a. Facility Name (If not institution,	give street an		LONG	4b. City	, Town, or	Location of		1100001	4c	. County of De	
Exami	iei	HOLY CROSS HOS				SII	VER :	SPRIN	G		Mo	ONTGOME	ERY
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.			r 1 Year	If Under		8. Date of B (Month, D			hirthplace (State or Foreign Country)
Director		237-92-6250	1 M 2 G	82	Yrs.					DECEMB	ER 1	NOF	RTH CAROLINA
and and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
Mary 1 sh	to	DC		WAS	SHINGTO	N,DC							1 X Yes 2 ☐ No
ith the Marylar or 28e-f show	lrec	10e. Street and Number				10f. Z	ip Code				10g. Cit	tizen of What	Country?
death with the Maryland rms 23e or 28e-1 show rmsst.be retilied at	Funeral Director	4205 ILLINOIS					200					.S.A.	
after dea or Items	nue	11. Marital Status	Arme	Decedent Ever in Led Forces? Yes 2 X No	J.S. 13.	Was Deci If Yes, sp	edent of Hi ecify Cuba	ispanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wi	nerican Indian, hite, etc.
72 hours aft natural; or	by F	1 Never Married 2 Marri 3 XWidowed 4 Divorced	If Ye	s, Give or Dates:		1 🗌 Yes	2 X No	Specify:				Specify:	BLACK
oe filed within 72 hours after all Hygiene Jother than "natural; or Ite	ted	15. Decedent		atodi	16a. Dece	dent's Us	ual Occupa	ation during mos	t of work	ina	16b. K	ind of Busines	ss/Industry
thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	1	ege (1-4or 5+)	life.	DO NOT	use retired)	t or work	ii i g	DDT	\$7 A TO E2	
led will ygien lygien her th	S	6th	(DOM	ESTI	j i	10 Moths	rda Name	e (First, Middl		VATE	
yland buld be fill Mental H arked oth attc even	Be	17. Father's Name (First, Middle, MATTHEW FIS)							MPTE		BAS		
2 should be and Mental fis marked craumatic ev	2	19a. Informant's Name/Relations		t)	19b. Maili	ng Addres	ss (Street a					or Town, State	. Zip Code)
2 2 2 2 2		MILTON LONG/S			105	01 M	ontan	a Ter	r. I	Largo,	Mary	land 2	0774
Darimore, IN permit. Pages 1 and 2 Department of Health Important: If them 27 1 any inlury or other tre once.		20a. Method of Disposition			Place of Dispo	osition (Na matory or	ame of other plac	e)		Date	20c. L	ocation - City	or Town, State
Page nent (1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Si			ckcreek	с Сеп	etery	7	8/12	/05	Wash	ington	,DC
Dartillor permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service	Licensee					s of Facilit					RAL HOME
T 405 # 9		1 10	5		th. Do not en							MARYLA	AND 20785 Approximate
certificate be executed certificate be executed right physicien and itse as the burial-transit	Ilcal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Demenita Demenita De to (or as a conse Urinary De to (or as a conse	quence of): Tract	Infe	ectio	n					
the death certific ty the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	10	s, outcome of pregr Live birth 2 ☐ Fet Pregnant at time of Unknown	al death 3[□Ectopic □ Other (s	pregnancy specify)					23d. Date of o	delivery Day Year
w requires that been signed be should be deta	by	Part II. Other significant condition	ons contributing	g to death but not re	sulting in the u	ınderlying	cause give	en in Part I					to the cause of death? Probably 4 Munknown
has be a	Completed									24a. Wa aut per 1 Yes	opsy formed?	prior t death	autopsy findings available ocompletion of cause of ? es 28 No
ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?					T -		of Deat	h (Check only	one)		
Physician: Physician: rthis certific ral director,	P	1 ☐ Yes 2 🛣 No	Hospital:		ER/Outpatie			4 🗆 110	ursing Ho			6 Other (S	ресіfy)
fter ng	ation:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g	Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injun Worl	yat k? Yes 2□	No	28d. Describe	now inju	ry occurred	
i Diff o	Certification:	3 Suicide 6 Could determ		Place of Injury - At I building, etc. (Spec	home, farm, st	reet, facto	ry, office				(Street ar own, State		Rural Route Number,
To the Hospitel within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	Examiner: On	To the best of my kr the basis of examin I manner stated.	nowledge, dea nation and/or in	th occurre nvestigation	d at the tin on, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	e cause(s e, date an	e) and manner d place, and d	as stated. ue to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifie	r	/		2	9c. Licens	e number			29d. Da	ate signed (Mo	onth. Day, Year)
		> They	ra	Me			D323	32			Aug	ust 8	2005
(2)		30. Name and address of person											
		SK Eupta M.D. 31. Date filed (Month, Day, Year)					Silve	r Spi	ring	, Maryl	and	20902	
St Regist	tate trar	ALIG 1 0 2	005	Hegistrar's Sign	K Son	de							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Eva Belle Laughrey 5 2005 /Medical 10:42A August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8313 Cagle Road Prince Georges Fort Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 21 F Director 90 180-20-0542 16,1915 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 ia marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Nedical Examinar must be notified at Directo Maryland Prince Georges Fort Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8313 Cagle Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ SpecifyWhite 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 Ia marked other than ** any injury or other traumatic event, if a Med any injury or other traumatic event, if a Med app. gangs. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Williamshouse Corp. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank R. Richev Ruth M. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda L. Zelnick/Daughter 8313 Cagle Road Ft. Washington, MD. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State

'4 □ Donation 5 □ Other (Specify) Scottdale Cemetery 8/06/2005 Scottdale, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityGeo. P. Kalas Funeral Home, P.A. 6160 Oxon Hill Road Oxon Hill, MD.20745 23a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a To the Hospital or Attending Phyalcian: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 autopsy performed? certificate 2X No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death | Director: / d in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide vithin 24 hours are To the Funeral Dir 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santiago D. Morao, Jr., M.D. 6357 Oxon Hill Rd. Oxa Hill, Md. 20745

State

AUG 0 9 2005 Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 05, 2005 **Physician** John Archie Malloy 3:00 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6482 Bock Road Oxon Hill P.G. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 05/15/1946 Birthplace (State or Foreign Country) **Funeral** Days 1 13℃M 2 1 F 59 Director N. Carolina 577-58-1460 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ral', or items 23a or 28a-f show Examiner must be notified at P.G. Oxon Hill 1 ∏Yes 2 ∏No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6482 Bock Road 20745 USA Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23 ury or other traumetic event, it a Medical Example must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ¬Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Black Specify: 3 Widowed 4 Divorced ear or Dates: Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) Painter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Neil O. Malloy Edna Cole မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10847 Nautica Place; Waldorf, MD Patricia Jordan - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Riverdale Crematory 08/12/2005 Riverdale, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Freeman Funeral Services P.O.Box 416; Suitland, MD 20752 DUCe. 23a. Part 1. Extended disease, or comprileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hair failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENCEPHALOPATHY /Medical Due to (or as a consequence of) Examiner TAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami FAILURE HEPATIC Due to (or as a consequence of) ECOMPENSATER CIRRHOSIS Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown pinous peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🔀 No Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ⊋ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 № Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2 M.D. 10 05 1)50457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Brian A. Chiqbuc, M.D.

AUG 1 0 2005

31. Date filed (Month, Day, Year)

Box 68760,

P.O.

Records,

of Vital

Division

2. Registrar's Signature

79.3 Central Ave. Caritol Heights, Md. 20743

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 John Robert Mitchell, Sr. **Physician** ү*өа*г 05 2:30 PM **04** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Clinton Nursing & Rehab Center If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 01-28-16 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Hours Min Director 224-16-5132 Virginia Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show other traumatic event, the Medical Examinar must be notified at Washington DC 1XYes 2 □ No Director or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 20020 USA Items 23a 2907 Gainsville Street NE Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X vidowed 4 □ Divorced Black "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk **GSA** 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Mary Pendelton James Elijah Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6612 Dunnigan Drive Clinton, MD 20735 Department of Health a Important: If item 27 Is any injury or other tra ance. John R. Mitchell, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State 08-11-05 Suitland, MD Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral rvice Licenses 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd. Camp Springs, MD 20748 Power. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetrand Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a conseque Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death for in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 20 No 1 Yes 25. Was case referred to medical examiner? 26. Plage of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No 1 🗌 Yøs 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 V Natural 5 Pending Injury 1 TYes 2 No after death. Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2. 29b. Sign dure and title f certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa 7700 Old Branch Avenue Suite C-101 Clinton, MD 20735 31. Date filed (Month, Day, Year) State AUG 1 0 2005 Registrar

		•	For State Registrar		State o	f Mary		epartment <i>Certificate</i>				lental Hy	giene Reg. Na		່	200
	Physicia	an	Decedent's Name (First,				M 1	1				2. Date of De Month August 8,		Yea	(3.	3 Death
	/Medic	al	4a. Facility Name (If not in:	dward	B.		Mad		Town, or	Location of		August o,		. County of De		40 A M
	Examin	er ×	Suburban Hospi			,			esda					ontgomer		
4	Funeral Director		5. Social Security Number 579–14–6970		x XM 2□F	7. Age (II 83	n yrs. last birtho Yr	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da NOV • 22,	th ly, Year) 192	9.8	irthplace (St Country) Mary	ate or Foreign land
	and w		Usual Residence of Deced 10a. State 10b. 0	County		10	Oc. City, Town o	r Location							10d. Insi	de City Limits
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9	after d	Funeral	1 Never Married 2	Marned	Armed Fo	orces? 2 No ve		If Yes, spec	ify Cuba	n, Mexicar	, Puerto	Rican, etc.)		Black, Wi	nite, etc.	
003	ural', c	d by	3 ☐ Widowed 4 ☐ Di		Year or D	oates:	WII	1 ☐ Yes 🔏		Specify:				Specify:	White	
15-	in 72 h	Completed	(Specify only		de completed)		16a. D	ecedent's Usua Bive kind of wor fe. DO NOT us	l Occupa k done d e retired	ation <i>Juring</i> mos ')	t of work	ing	16b. K	and of Busines	ss/Industry	
212	filed within Hygiene. other than "	mo	Elementary/Secondary ((0-12)	Coltege (1-4or 5+)	Tru	ck Driver					Fede:	ral Gove	rnment	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23a or 28a-1 show any Injury or other traumatic avant, the Medical Examinar marke prolified at once.	Be	17. Father's Name (First, I									e (First, Middle,		Sumame)		
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22	North Str		23a. Part . Enter the dise shock, or heart failur	ase, or comp	lightions that	caused the	e death. Do no							<u>ana 20</u>	Approx	
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	/Medical Examiner		resulting in death)		Due to	(or as a co	onsequence of)	: /								
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8760,	cate be executed oblysician and the burial-transit	EX	resulting in death) Last		Due to	(or as a co	onsequence of)									
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Box (The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregn	nant	23c. If yes, ou		oregnancy Fetal death	3 ☐ Ectopic pre						23d. Date of d	lelivery	
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٥	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely lilled in by the fune		29a. Certifier 1 ☐ C	ertifying Ph	sician: To the		ny knowledge	leath occurred	at the tim	ne date an	nd place	Road, F	-+,	Washi	ingtor	1, MD
	te Hos 124 hc te Fun	edical		ledical Exam	iner: On the b	pasis of ex	amination and/	or investigation,	in my of	pinion, dea	ith occur	red at the time,	date and	d place, and d	ue to the car	use(s)
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CR	(6)		30 Name and address of	omski	completed cau	se of deat	h (Item 23a) (T	Print) 1/e	Pi	ke,	G-1	00, R	ac t	ville.	MD &	10852
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				1 - For State Registrar	State of Ma	aryland .		rtment of F tificate of	tealth and I <i>Death</i>	-	giene Reg. No2 / / /	15 25	1630	
		Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De		Year 3	me of Death	
		/Medi	cal	Da Da Da Da Da Da Da Da Da Da Da Da Da D	vid I. Mey	rer		4b. City. Town, o	or Location of Deatl	Auch	4c. County	005 129	46 P	
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	10	- Funeral - Director		216-30-8400		70	Yrs.	Months Days	Hours Min.	June 1	y, Year)	Country) Maryla	1	
		should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23a or 28e-f ahow unatic event, it a Medical Ever in at marke a notified at	o.	Usual Residence of Decedent 10a. State 10b. County Maryland Carre	211	10c. City, T	own or Loc		ykesville				ide City Limits Yes 2 ☐ No	
		7.28e-	Funeral Director	10e. Street and Number	<u> </u>	L		10f. Zip Code	ykesviiie		10g. Citizen of W	/hat Country?		
		h with	I D	3100 Jefferson A	venue				21784		U	.S.A.		
		ems 2	Inera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	Vas Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race Blace	- American Indi k, White, etc.	an,	
	920	ours atte	5	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:		55 1	□ Yes 2🏻 No	Specify:		Specify	Whit	e	
	215-0	nin 72 ho n "nætur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or :		(Give F	ent's Usual Occup kind of work done OO NOT use retire	during most of wor	rking	16b. Kind of Bu	siness/Industry		
	212	giene giene er the	EO	unknown	unknown	.,		Stocke	,			nknown		
	land	ild be file lental Hy ked oth Ic event	To Be (17. Father's Name <i>(First, Middle, Last)</i> Maurice					18. Mother's Nar	ne <i>(First, Middl</i> e, Gertrud	Maiden Sumam e Brown	a)		
	ary	shou and N s mar	-	19a. Informant's Name/Relationship (Type, Print)				and Number or Ru					
	Σ	and 2 salth in 27 i		Aimee Saylor, Eligibi	lity Clerk				althcare Sy					
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28e-1 show any lojury or other traumatic event, its Medical Eventual for motified at once.		20a. Method of Disposition 1 ☎ Buriaf 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi		Garrison Forest Cemetery 08/11/05 Owings Mi								
	Balt	permit. Departr Imports any Inju		21. Signature of Funeral Service Licer	. Tare	Dong	Le	e A. Pat	ess of Facility terson & . Marylai	Son Fun	eral Hom 3 - 0766	ne, P.A.		
		4		23a. Part1. Enter the disease, or com shock, or heart faifure. List only	plications that caused one cause on each li	the death. I	Do not ente	r the mode of dyi	ng, such as cardia	or respiratory a	rest,	Interv	oximate al Between	
		Physician		Immediate Cause (Final disease or condition	· Acui			*	nfarcte			/ A	t and Death	
		/Medical Examiner		resulting in death)	Due to (or as	a consequen	ice of):							
you	4		-	Sequentially list conditions,	b. Due to (or as	a consequen	ice of):					10 4	rears	
		t insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,								
	,092	e be executed sicien and a burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequen	ice of):							
	89	tifficat ng phy as th	ledi											
	Division of Vital Records, P.O. Box 687	Attending Physician: The law requires that the death cartificate be rideath. sctor: Atter this certificate hes been signed by the attending physicie by the tuneral director, page 2 should be detached for use as the but	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3 🗌	Ectopic pregnanc Other (specify) _	у		23d. Date Mor	e of delivery oth Day	Year	
	P.	thet the de ed by the detached	Phy	Part II. Other significant conditions of	ontributing to death b	out not resulting	ng in the un	deriving cause gr	ven in Part I.	23e. Did to	obacco use contr	ibute to the caus	e of death?	
1	ds,	uires t signé ld be	d by	chronic obstr	6	pulm		A	ease.	1 🗆 🕻	res 2 □ No	3 Probably	Unknow	
110	00	s beer	lete					J		24a. Was	an 24b. V	Vere autopsy find rior to completion	dings availab	
Jas	al Re	: The la cate hes	Completed by							1 Tes	2 No 1	rior to completion leath?		
	V.	eiclar certif recto	Be C	25. Was case reterred to medical examiner? 1 Yes 2 No	Hospitaf. 1 ☐ Inpatie	- Arn	/Outpatient	Ott Box Ott	her	ath (Check only o				
3	ō	Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju (Month, Da		b. Time of	3 □ DOA □ 28c. Inju			dence 6 Other			
Meyek.	> <u>5</u>	ath. r: Atte	atlo	1 Atural 5 ☐ Pending 2 ☐ Accident investigation		ly Year)	fniury		rk?]Yes 2 □No					
2	Divis	al or Atte t atter de I Directo d in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number City or Town, State)							or Rural Route	Number,		
		To the Hospitel or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: Atter this certificate hes been signed completely tilled in by the tuneral director, page 2 should be de	Medical C	29a. Certifier Certifying Ph (Check only one)	ysician: To the best ninar: On the basis o and manner st	f examination	dge, death and/or inv	occurred at the ti estigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mai date and place, a	nner as stated. Ind due to the ca	tuse(s)	
		To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date signed	(Month, Day, Y	ear)	
				Chemme of	In a man	D .		122	264F		08/08/20	105		
	-	VIA		30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type, F		•		,			

DHMH 17 Rev 1/2001

State

Registrar

AUG 1 0 2005

Jerone I. SJYDER M.D. 900 SOUTH CATON INVENUE BALTIMORE MARYLAND

31. Date filed (Month, Day, Year) 1 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item I per dyr 9846 8-23-05 vt

Derothy	State			tificate of l	Death		9. NQ () (5	2761.0
- Derothy		Dorothy		Proctor		2. Date of Deat		3me of Death
acility Name (If not institution	F		Pr	octor_	Location of Death	August 16,	2005	12:45 A M
outhern Marylan		umber)						
cial Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 2	Prince Ge	Links In an /Chake an Francisco
78–36–2759	1□M 2/□ F	84	Yrs.	Widthis Days	Tiours Iwin.	January 2	8. 1921	Country) Maryland
State 10b. Count	ty	10c. City	Town or Lo	cation				10d. Inside City Limits
ryland Char	les		Bryanto	wn				1 ☐ Yes xxxx No
Street and Number 3285 Langley Ro	vad			10f. Zip Code 20617		10	ng. Citizen of What USA	Country?
Marital Status	Armed F		S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
Never Married 2 Ma XXWidowed 4 Divorce	If Yes, G	: <u>≵⊠N</u> o Sive Dates:		I□Yes 2,©TNo	Specify:		Specify:	Black
15. Decede	ent's Education		16a. Deced	lent's Usual Occup	ation	:	16b. Kind of Busines	ss/Industry
(Specify only night ementary/Secondary (0-12)	nest grade completed) College	(1-4or 5+)		king of work gone of 00 NOT use retired Employed	during most of worki	ing	Harralasas	-
ather's Name (First, Middle	0 (001)		Serr-	unibrokea	18. Mother's Name	/First Middle A	Housekeepe:	<u>r</u>
Joseph C. Savo	,				Rosetta Sa		maruen Sumame)	
Informant's Name/Relation			19b. Mailin	g Address (Street			City or Town, State	, Zip Code)
semary Poteat /	Daughter		145 Wo	od Duck Cir	rcle LaPlata	a, Marylan	d 20646	
Method of Disposition t⊠ Burial 2 ☐ Cremation	n 3 □Removal from	20b. Pla ce	ace of Dispo metery, cren	sition (Name of natory or other plac	:e)	Date	20c. Location - City	or Town, State
4 ☐ Donation 5 ☐ Other ((Specify)			Cemetery		20, 2005	Indian Head	d, Maryland
Signature of Funeral Service	licensees	<i>f</i>) -	61	. Name and Addre 60 Oxon Hil	ss of Facility L1 Road Oxor	ge P. Kali Hill, Ma	as Funeral I ryland 20	Home P.A. 745
Pa 11. Enter the disease of shock, or heart failure. Lis	or complications that ist only one cause on	caused the death	. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
ediate Cause (Final ase or condition Iting in death)			-	XIC CA	MIXOCHIC	COUNT	DUEALE	
	Due to	o (or as a consequ	ence of):					
uentially list conditions, y, leading to immediate se. Enter Underlying se (Diseese or injury	b. Due to	o (or as a consequ	ence of):					
se (Diseese or injury initiated events Iting in death) Last	C							
ing in douti) East	Due to	o (or as a consequ	ence or):					
	d	<u></u>						
EMALE: Was decedent pregnant		outcome of pregnar		Ectopic pregnancy			23d. Date of c	
in the past 12 months? 1 Yes 2 No		gnant at time of de		Other (specify)			Month	Day Year
9 Unknown II. Other significant condit	itions contributing to	death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
FAILUNE	TO	THRI				1 □ Ye	s 2 X No 3	Probably 4 Unknown
						24a. Was ar	24b. Were	autopsy findings available
						autops perform		
	cal				26. Place of Death			
Nas case referred to medic		npatient 2 E			4 Nursing no		nce 6 Other (S	pecify)
examiner?	ding (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	28a. Describe no	w injury occurred	
examiner? Yes 2 No Manner of Death Natural 5 Pend	ld not be 28e. Plac	ce of Injury - At hor	me, farm, str			28f. Location (Str	reet and Number or	Rural Route Number,
examiner? Yes 2 No Manner of Death Natural 5 Pend Accident Investigation Suicide 6 Could	Dull	laing, etc. (Specily,	/			City of Yowin	, State)	
examiner? Yes 2 No Yes 2 No Anner of Death Natural 5 Pend inves Accident inves Sign Suicide 6 □ Could								
Anner of Death Natural As Accident investing the could determine	al Exeminer: On the	basis of examinati	on and/or in					
examiner? Yes 2 No Manner of Death Natural 5 Pend inves Accident inves Suicide 6 Could Certifier 1 Certify Check only 2 Medica	al Exeminer: On the and ma	basis of examinati	on and/or in	29c. Licens	e number	25	d. Date signed (Mo	nth, Day, Year)
examiner? Yes 2 No Aanner of Death Natural 5 Pend inves Accident 5 Could Under the could Under the could Could Under the could Under	al Exeminer: On the and ma	basis of examinati	on and/or in	-	105111	1		nth, Day, Year) 16, ZEES Ud. ZEED
xam Y D	Accident inves	Accident investigation Suicide 6 Could not be determined 28e. Pla buil	Accident investigation 28e. Place of Injury - At horizontal determined 28e. Place of Injury	Accident Suicide Homicide Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specily) Certifying Physicien: To the best of my knowledge, death seck only Medical Exeminer: On the basis of examination and/or in	investigation Suicide Homicide Could not be determined Could not be determined Could not be determined Could not be building, etc. (Specify)	Accident Suicide Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Accident Suicide Homicide Could not be determined Could not be determined Suicide Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town tiffer 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the casek only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place in the time, death occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time of the occurred at the time occurred at the time of the occurred at the time occurred at the time of the occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at	Accident Suicide Homicide Investigation Gould not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or City or Town, State)

		For		Si	ate of	Marylan	d / Depa				and M	ental Hy	giene			
		State Registrar					Cei	rtificate	of D	eath			Reg. No.	0.05	2764	
Physicia		Decedent's Nam Doro		o, Last) L	•	Pa	rk					2. Date of De Month	Day	2005	- GG/S	h N
/Medic Examin		4a. Facility Name	(If not institution	, give stree	t and numb	er)		4b. City, T	own, or t	_ocation o	of Death	0	4c. (County of De	ath	
LAGIIIII		Doctor	's Comm	unity	Hosp	ital		Lanl	ham				Pr	ince G	eorge's	
Funeral		5. Social Security I	Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under 1		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Bi	irthplace (State or For	
Director		249-76-3		1 □ M	2 28 F	60	Yrs.		,,			June 2	-	(:00	rgetown, S	C
and		Usual Residence of 10a. State	10b. County			10c. Cit	ty, Town or Lo	ocation	-						10d. Inside City Lin	nits
Many	ō	MD	Prince	Geor	ge's	La	nham								1 ∳ Yes 2 □	No
r 28a	Director	10e. Street and No	umber					10f. Zip 0	Code				10g. Citiz	en of What C	Country?	
th with		9207 4t	h stree	t					20	706			Unit	ted St	ates	
ified within 72 hours after deeth with the Maryland Hygiene. Hygiene. The Wardleal Exame at most ten notified at any, the Mardleal Exame at most ten notified at	Funeral	11. Marital Status			Was Decede	ent Ever in U	.S. 13.	Was Decede	ent of His fy Cuban	panic Ori	gin? (Spe	cify Yes or No lican, etc.))- 1	4. Race - Arr Black, Wh	nerican Indian, lite, etc.	
s afte	by Fu		rried a Marr 4 Divorced		☐ Yes 2 f Yes, Give fear or Date			1 ☐ Yes 2	No No	Specify:				Specify: B	lack	
hour			15. Deceden				16a. Dece	dent's Usual	Occupat	tion				nd of Busines		
nin 72	Completed		cify onfy highe	t grade coi		or 5+)	(Give	kind of work DO NOT use	done du	ırina mosi	t of workin	g			,	
d with giene	E O	Elementary/Sec	ondary (0-12)		Johneye (1-4	0, 3+)	Caf	eteria	a Ma	nagei	r		Foo	od Ser	vice	
is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Maralla hygiene. The lift heeth and Maralla hygiene a few or items 23a or 28a-fehow other traumatic event, the Mardical Example at minimal two notified at	Be (17. Father's Name	(First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	, Maiden S	Sumame)		
should be nd Mental marked o	2	Willie								_		obinso				
2 short and is m		19a. Informant's h										Route Numb			Zip Code)	
T end 1 end 1 eelth 1 m 27 1 her tr		20a. Method of Dis	Park (husb	and)	20h F	9207 Place of Dispo	4th st		t I		m, MD			or Town, State	
Peges tment of trant: If the tant: If the ijury or o		1 Burial 2	Cremation		val from St	010	Linco	matory or oth	ner place		8/12/		_	wood.		
iit. Posttani		* 4 ☐ Donation 21. Signature of F	5 Other (S		·							t Linc				
permit. Peges 1 end Depertment of Heelt Important: if item 2 eny injury or other		Lui	1 1	1000	6/_							d Bre				
		23a. Part1. Enter	the disease, or	complication	ons that cau	sed the deat								, III	Approximate Interval Between	
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/Medical		disease or conditi resulting in death		a	Due to (o	as a consec	uence of):	+								-
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po ts	Examiner	if any, leading to i cause. Enter Und Cause (Disease o	immediate terlying	Į	Due to (or	as a densed	uence of):									
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icate be executed physicien and sthe burial-transit	al E						, , , , , , , , , , , , , , , , , , , ,									
ficate ficate phys	edical			d					-							
onding use a	Physician/Me	IF FEMALE: 23b. Was decede	nt pregnant			me of pregna		75-4					2	3d. Date of de	elivery	
death	sicla	in the past 1:				nt at time of c		Ectopic pred Other (spe						Month	Day Year	
at the lby th	hys	9 □ Unknow														
The cold day, T.C. BOX 80100, The law requires that the death certificate be executed the has been signed by the ettending physicien and page 2 should be deteched for use as the burial-transit	by	Part II. Other sign	ificent conditie	ons contribu	uting to dea	th but not res	sulting in the u	nderlying car	use give	n in Part I.	•	23e. Did			to the cause of death' Probably 4 □Unkno	
w requires to been signer should be	Completed															
e law has t	mpl(24a. Was		24b. Were a prior to death?	autopsy findings availa completion of cause	able of
len: Th		144										1 Yes	2 No		s 2 No	
Physicien: r this certific	o Be	25. Was case reference examiner?	erred to medica	Hosp	ital:	atient 2	ER/Outpatier	nt 3□ DOA	Other	r		(Check only ne 5 ☐ Resi		DOther /Co	and the second	
Phy er this	H- 1	27. Manner of Dea			8a. Date of	Injury	28b. Time o		c. Injury	at		8d. Describe			өспу)	
nding ath. r: Afte e fune	atlo	1 Natural 2 Accident	5 🗌 Pendir investi		(Month,	Day Year)	Injury	М	Work′ 1 □ Y	es 2 🗌	No					
r Atte	Certification;	3 Suicide 4 Homicide	6 ☐ Could determ		8e. Place of	f Injury - At h	ome, farm, str	reet, factory,	office		2	8f. Location (Street and wn, State)	Number or F	Rural Route Number,	
ital o rel Di led In	Cer															
Hosp 14 hou Fune tely fil	edical	29a. Certifier (Check only	Certifyin 2 Medicel	Exeminer:	On the bas	is of examina	owledge, deat ation and/or in	h occurred a vestigation, i	t the time in my opi	e, date an inion, dea	nd place, a ith occurre	nd due to the d at the time,	cause(s) a date and	and manner a place, and du	as stated. ue to the cause(s)	
To the Hospital or Attending Physicien: The law within 24 bours effer death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 to	Med	one)	b little of certifie		and manne	r Stated.		29c.	License	number		T	29d. Date	signed (Mor	nth, Day, Year)	
¥ ¥ ₹ ĕ		de	Vicen	70	How	Q V	M()	7	125	298	27		5	XIL	2005	
10		30. Name and ad	ess of person	who compl	eted cause	of death (Iter	m 23a) (Type.	Print)	10.	210	2)		(2/0		
0		Ton	REY)	H		575			28.1	50	172	357	LAU	LEL,	MO 2070	7
Sta		31. Date filed (Mo				gistrar's Signa										
Registr	ar	AL	JG 1 0 7	2005	HUS.	u , 🔎	S doe	els)								

.1 1,	copies		For Stata Registrar	State of Ma	ryland / Dep		of He	alth an	-	giene		
Sir Co	Physic /Medi		1. Decedent's Name (First, Middle, Las John Arthur People	,					2. Date of De Month August	Day	005 Year 2005	02:47 A
	Exami		4a. Facility Name (If not institution, give	,				ocation of D		4c.	County of Dea	
Stories Co.	Funeral		302 Little New Your Social Security Number 6. Secur	7. Age	(In yrs. last birthday)	If Under 1	sing Year Days	If Under 24 I	Hrs. 8. Date of Bir		Cecil 9. Bir	thplace (State or Foreign
	Director		212-02-0130 Usual Residence of Decedent	X M 2□F	23 Yrs.	Willing	Days	Hours	Mrs. 8. Date of Bir (Month, Da July 21	2, 19	82	DE
	r 28a-f show	-	10a. State 10b. County		10c. City, Town or Lo							10d. Inside City Limits
	r 28a-f	recto	MD Cecil 10e. Street and Number		Rising.	Sun 10f. zip 0	Code			10a, Citiz	en of Whai Co	1 Yes 2 No
	23a or	aiD	102 Cissel Lane			21	911			us		
980	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jical Examiner must be natified	by Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	0	Was Decede If Yes, specif 1 ☐ Yes 2		panic Origin? Mexican, Po Specify:	(Specify Yes or No uerto Rican, etc.)		4. Race - Ame Black, Whit Specify: Who	e, etc.
Maryland 21215-0036	C * 3	Completed	15. Decedent's Ed (Specity only highest grad Elementary/Secondary (0-12)		- (Give	dent's Usual kind of work DO NOT use	done dur retired)	on ring most of	working		d of Business	/Industry
1d 2	il Hygie other t	Be Co	12 17. Father's Name (First, Middle, Last)			on Wor		8. Mother's i	Name (First, Middle,	Ir Maiden S		
ylar	ould be Menta Parked	ToB	John Peoples						e Freese			
	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M		John Peoples/fat						Rural Route Number			
Baltimore,	ges 1 a it of Hea if item or othe		20a. Method of Disposition 1 Disposition 2 Cremation 3		20b. Place of Dispo cemetery, crei	sition (Name natory or oth	of er place)	1020	Date		ation - City or	
Itim	it. Pa rtmen rtent: njury		4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Service License)	Rosebank	Cemet	2ry Address	08-	11-2005	Ri	sing Su	in, MD
Ba	Depa Impo eny l		Keepard 7	Pora	20.	111 5.	Que	en Str	.T. Foard eet, Risi	ng Si	eral Ho un, MD	ome, P.A. 21911
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	consequence of):		of dying, :	such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	certificate be executed rding physician and ise as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):							
P.O. Box 6	death e atter	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic preg Other (spec				23	3d. Date of deli Month	very Day Year
	w requires that the de been signed by the s should be detached t	ed by P	Part II. Other significant conditions co	ntributing to death but	nol resulting in the u	nderlying cau	se given i	in Part I.	23e. Did to	t	,	the cause of death?
Division of Vital Records,	The law ate has b page 2 st	e Completed by	25. Was case referred to medical						1 Yes	sy med? 2 \(\text{No} \)	24b. Were au prior to death? 1 Yes	topsy findings available completion of cause of
of Vi	Physicien: this certific ral director,	ToB	examiner?	lospital: 1 ☐ Inpalient	2 ER/Outpatien	t 3 DOA	Othor		eath (Check only or Home 5 Resid		XOther (Spec	uty) SCENE
ou o	ding P th. After t funera		27. Manner of Death 1 □ Natural 5 □ Pending 2 Na Accident Investigation	28a. Date of Injury (Month, Day	Year) Injury	28c	Injury all Work?	2 (No	28d. Describe h	ow injury	occurred dy	rver in
Divisi	ial or Attending s after death. I Director: After ad in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	v - At home, farm, stre			2.54.10	28f Location (S	itreet and in, State)	COUISIC Number or Au 302 hit	nal Route Number, He New York
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Certifying Phy 2 ☑ Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at restigation, in	the time, my opini	date and pla on, death oc	ce and due to the s	aughter -	nd manner as lace, and due	stated. to the cause(s)
	To T To I	Σ	29b. Signature and title of certifier				icense nu				signed (Month	
,	ŕ	-	30. Name and address of person who co	ompleted cause of dea	ith (Item 23a) (Type	İ	0.C.	м.Е.		Augus	t 07, 2	2005
(0		Pamela B 3vu	that, MI)	111		tree	t, Ba	ltimore, N	Mary1	and 212	201
	Sta Registr		31. Date filed (Month, Day, Year) ĀUG 1 0	32. Registrar	s Signature	Specie	A					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2005 AUGUST HENRY RUIZ 3:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death LARGO
If Under 1 Year | If Under 24 Hrs. 8 MANOR CARE NURSING HOME PRINCE GEORGE'S 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Min. 1⊠M 2□ F Hours Yrs. Director 50 212-11-0070 PERU February 2 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "netural", or items 23a or 28e-1 show 10a. State 10b County 10c. City, Town or Location iral', or items 23a or 28e-f show LExaminar insist be notified at 10d. Inside City Limits 1X Yes 2 ☐ No Director MD PRINCE GEORGE'S BRENTWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 NEWARK ROAD 20722 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married 0 1 Yes 2 □ No Specify: þ PERU Specify: HISPANIC 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER yrs PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FAUSTINO RUIZ EDITA SANTOS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong. FANY CARRENO/FIANCEE 3901 NEWARK RD BRENTWOOD, MARYLAND 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 8/9/05 RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician flio blastoma Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by I page 2 should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown \$ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 X No 1 Tes 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) င္ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation or Attending 1 🖾 Natural after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely fiffed in To the Hospital of within 24 hours a To the Funerel D 29a. Certifier (Check only one) Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce 29c. License number 29d. Date signed/(Month, Day, Year)

CR D

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

State Registrar Ayim Djamson M.D. 4000 Mitchellville Rd # 406 Bowie, Maryland 20735

31. Date filed (Month, Day, Year)

AUG 1 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of N	Maryland		rtment of F tificate of I	lealth and M <i>Death</i>	lental Hy	/giene Reg. No. 🔿 🗘	^~	
			Decedent's Name (First, Middle, Last)						2. Date of De	eath 20	05	2717 Fran5
	Physici /Medi		Mary Lou	Sn	nith				AUS.	B. J	Year 005	10:11 A M
	Examir		4a. Facility Name (If not institution, give s				•	Location of Death		4c. County		
			Peninsula Resiona	1 med:	cal C	enter	Salisb	ury		Wico	mico	
	Funeral		5. Social Security Number 6. Sex	7. /	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 7/15/1	rth ay, Year)	9. Birthp	lace (State or Foreign try)
	Director		214-30-8670	M 2.24F	76	Yrs.			7/15/1	1929	Mary	land
	p s		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	ation				1	0d. Inside City Limits
	sho	5	Maryland Wicomi	~		alisbu						1 ☐ Yes 2 XNo
	the Marylan r 28a-f show rediffed at	ect	10e. Street and Number				10f, Zip Code			10g. Citizen of	What Coun	trv?
	with	급	1705 Upper Millste	ono Tono				0.1				
	within 72 hours efter deeth with the Maryland ene. then "natural", or iteme 23a or 28a-f show the Mudical Ever it are must be mulified at	Funeral Director		2. Wes Deceder	nt Ever in U.S	6. 13. W	2180 Vas Decedent of H	U I lispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or N	USA 0- 14. Ra	ce - Americ	
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7 7	urs e	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:	1	☐ Yes 2XX No	Specify:		Speci	y: W	hite
	72 hours "natural",	sted	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Decede	ent's Usual Occup	ation during most of work	ina	16b. Kind of B	usiness/Ind	lustry
J 2	within 72 ho liene. r then "natu	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)			3)	,			
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S Pri	be fill d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name			110)	
Maryland	should I	J.	Preston W. Burbage			10h Mailin	Address (Ctreat	Nannie and Number or Rura			State Zin	Code
7 2	d 2 st h and 7 ie n treun		19a. Informant's Name/Relationship (Type France E. Smith/hi				, , ,	Millstone				
	Heeli Heeli ther		20a. Method of Disposition	abbana	20b. Pla	ace of Dispos	ition (Name of		Date	20c. Location		
	ages int of t: if th		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	[™] Wic	comico	Memoria.		1/05	Salisb	iru l	MD
Me	permit. Pages 1 and 2 should be filed within Depertment of Heelih and Mental Hyglene. Importent: If Item 27 is marked other then any injury or other freumatic event, Item and once.		21. Signature of Funeral Service License	θ	Par		Name and Addre	1	·			
a a	permit. Deperting		VIICHOU	1 00	-SP	HC 50	olloway b 11 Snow b	funeral Ho Hill Rd.,	ome Pro Salish	tession Jury MD	al As: 2180	sociation
			23a. Part1. Enter the disease, or comple	ations that caus	ed the death.						2100	Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final		2170		of se	tun			0	Onset and Death
	/Medical		disease or condition resulting in death)		as a consequ		21/ 22	40.4			0	1001/2)
	Examiner		Commence the first conditions									
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a c	eath certifi attending	clan	in the past 12 months?	1□Live birth 4□Pregnant	2 Fetal	death 3	Ectopic pregnancy Other (specify)	1				Day Year
C	by the a	Physician/M	1 Yes 2 No	9□ Unknown			- (apoony)					
Δ	law requires thet the death certifiav requires thet the death certifias been signed by the attending 2 should be detached for use a	y Ph	Part II. Other significant conditions con	tributing to death	but not resu	lting in the un	derlying cause grv	en in Part I.	23e. Did	tobacco use con	tribute to th	e cause of death?
200	ld be	d by							1 🗆	Yes 2 No	3 🗌 Prob	ably 4 Unknown
5	w require been signature should b	lete							24a. Was		Were auto	osy findings available
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<) 7	icien: Th certificate rector, pag	C	25. Was case referred to medical					26. Place of Deatl	1 ☐ Yes		1 1 102	2 140
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يَ رَي	Attendin death. ctor: Af y the fur	atlo	2 Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,		Yes 2 □No				
1	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building,	Injury - At hor etc. <i>(Specify)</i>	me, farm, stre	et, factory, office		28f. Location City or To	(Street and Numi wn, State)	ber or Rura	Route Number,
	rel D	Cel					·					
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ti	Medical	one) 29b. Signature and title of certifier	and manner			29c. Licens	e number		29d. Date signe	d (Month, i	Day, Year)
	E ≥ E 8		1 Sty Varit	· M.	0.		Di	0690		tue	9 2	2005
	100		30. Name and address otherson who co-	mpleted cause o	f death (Item	23a) (Type: F	Print)			7, 7,	1	
	100		30. Name and address of person who co	AT,N	M.O	. 14	P5 E .	Cerrol1	57.	5.1:56	レケラ	MD,
1	St	ate	31. Date filed (Month, May 1 Year) 0 2	005 32. R	strar's Signati	ure L	1.4.		-			
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			1 - For State Registrer	State of Ma		artment of Hartificate of L		d Mental Hyg							
			Registrer 1. Decedent's Name (First, Middle, Last)		O G	Tillicate of L	Jeani	2. Date of Deat	ng. No. []	5 21	S L S				
	Physici		Donald L. Smalls	Sr.				Month August	7 200	Year	L:56p ^M				
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of De		4c. County		ор				
Н			Suburban Hospital			Bethesda	ı		Montgo	omery					
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H		Year)	9. Birthplace (Sta Country)	ite or Foreign				
	Director		233-56-9703 Usual Residence of Decedent		66 Yrs.					Vest Virg	inia				
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Insid	le City Limits				
	Mary Feet	to	Maryland Prince Ge	orge	Greenbelt					150	Yes 2 □ No				
	h the	rec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of W	/hat Country?					
	23e C	alD	7720 Hanover Parkw	ay, Unit	304	20770			USA						
	tems	by Funeral Director	11. Marital Status	Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- American Indiai	٦,				
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21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28a-1 show its Medical Exis "illet" sast be italified at	Completed	(Specify only highest grade	completed)	(Give	kind of work done di DO NOT use retired)	uring most of w	vorking	16b. Kind of Bu	siness/industry					
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yla	ould by Ment arked	Tol	Edward Smalls, Sr.				Amer	ica Martin							
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other traumatic event, If a Medical Examination at Demonstrated at ODGe.		. , , ,								00770				
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Ba	permi Depar Impor any ir		Dalla n	Intervention of Funeral Service Licensee Intervention formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7720 Havover Parkway, Unit 304, Greenbelt, MD 2077 20b. Place of Disposition (Name of cemetery, crematory or other place) Intervention of Funeral Service Licensee 22c. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722											
			23a. Part1. Enter the disease, or complic	ations that caused t	he death. Do not ent	OI Bladen er the mode of dying	sburg I	ac or respiratory arre	wood, M	D ZU/ZZ Approxi					
	Physician		Immediate Cause (Final	e cause on each line	cardial					Interval Onset a	Between nd Death				
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387		edicai	d.												
Box (death certifica attending ph d for use as t		IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome o	pregnancy				23d Date	of delivery					
	death e atte d for	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at ti		Ectopic pregnancy Other (specify)			Mon	,	Year				
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	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions cont	ributing to death but	not resulting in the un	nderlying cause giver	n in Part I.	23e. Did toba	acco use contril	bute to the cause	of death?				
ord	equir sen si ould		Myper TUISIO	1				1 🗆 Yes	s 2 □ No 3	3 ☐ Probably 4	D Unknown				
Records,	The law requires that the death certif sie has been signed by the attending page 2 should be detached for use a	Completed	Diabetes					24a. Was an autopsy	pr	ere autopsy finding	gs available of cause of				
		Con						perform	ed2 de	eath?					
Vita	icien certifi ector	Be	25. Was case referred to medical examiner?	ospital:		O#		eath (Check only one)						
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Division of	Attendi r death. sctor: A sy the fu	ifica	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, stre (Specify)			28f. Location (Stre		r or Rural Route N	lumber,				
	el or s afte	Certification:	4 Homicide determined	building, etc.	(Specity)	· ·		City or Town,	State)						
	To the Hospitel or Attending Physicien: whith 24 hours after deals at the furnital Director. After this certification the funeral Director. After the function in by the funeral director,		29a. Certifier 1 Certifying Physi	cien: To the best of	my knowledge, death	occurred at the time	o, date and place	ce, and due to the car	use(s) and man	ner as stated.					
	the H nin 24 the Fi	ledical	one)	and manner state	ed.			curred at the time, dai	e and place, ar	nd due to the caus	e(s)				
	To with	Σ	29b. Signature and title of pertifier		Δ.	29c. License	number	29	d. Date signed	(Month, Day, Year)				
^	0			ergency	Physician		+ +6		8/+/	05					
R	(5)		30. Name and address of person who cor				, Ho	0:418	600 C1	d georg	excun &				
	C)	10	31. Date filed (Month, Day, Year)	CONATO 32 Registrar		uburbar	, 110	& Ichid	ahesdo	Mod	0314				
	Sta Registr		AUG 1 0 2005		. I Lo	1									

Donald Smalls 8/1/05 1356

leven Stake 222-01-8320

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Vernon Edward Strobel, Sr. /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NICONICO 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 222-07-8320 Months Days Hours 1∭M 2□F 83 Yrs Director May 12, 1922 Maryland Usual Residence of Decedent death with the Maryland 10a, State permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, Ite Madical Examiner must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester Berlin Director 1 ☐ Yes XINo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 37 Newport Drive 21811 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WW∐] 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WWII Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Fireman D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Everhart Strobel Mary Elizabeth Biedabach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon E. Strobel, II Son 120 12th St. S.E. Washington, DC 20003 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 ☑ Cremation 3 ☐ Removal from State Cedar Hill Cemetery ` 4 ☐ Donation 8/12/2005 5 Other (Specify) Suitland, MD. 22. Name and Address of FacilityGeo. P. Kalas Funeral Home 21. Signature 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 des V / Part1. Enter the disease, or complication shock, or heart failure. List only one ca that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 2 No 1 Yes Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: Diractor: After this certific in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

To tha Funerel C

completely filled 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030743

Registrar DHMH 17 Rev 1/2001

State

Benjamin Mkg 31. Date filed (Month, Day, Year)

AUG 0 9 2005

400 Eastern Shore Dr. Salisbury, md. 21803

and addr ss of person who completed cause of death (It + 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Montal Hygiene

			For State Registrar		State of	f Maryla		artmen <i>rtificati</i>				ental Hyg	giene Reg. No. 🤈 (000	0
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	Exami		4a. Facility Name (If not inst			-				Location	of Death	,,,,		ty of Death	
	Francis		Doctor's Comm 5. Social Security Number	unity 6. Se			. last birthday	Lan If Under		If Under	24 Hrs.	9 Date of Birth			orge's
	Funeral Director		578-24-4245		3 M 2 □ F	79	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day June 20	Year) 1926	Wash	place (State or Foreign htry) ington, DC
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	shov	7	10a. State 10b. Co	unty			ity, Town or Lo							1	0d. Inside City Limits
	28a-f	ecto	DC 10e. Street and Number			W	lashing	ton 10f. Zip	0-4-						1 X Yes 2 No
	a or	Funeral Director	556 Peabody	Stre	et NW			TOI. ZIP		011			IOg. Citizen of USA	What Cour	itry?
	death ms 2	Jera	11. Marital Status		12. Was Dece	dent Ever in t		Was Deced	lent of Hi	spanic Or	igin? (Sp	ecity Yes or No-		ice - Americ	an Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any lajury or other treumatic event, the Medical Examinar must be notified at 200ce.	b	1 ☐ Never Married 2 📆 3 ☐ Widowed 4 ☐ Divo		Armed For 1 Types If Yes, Giv Year or Da	2 □ No e		lf Yes, spec 1 ☐ Yes 2	ify Cuba	n, Mexica Specify:	n, Puerto	Rican, etc.)		ack, White,	
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	and 2 salth ar					r						e Glend			
Baltimore,	es 1 and 2 of Health fitem 27 r other tre		20a. Method of Disposition			20b.							20c. Location		
Ë	Pages nent of int: If its iry or o			nod of Disposition Burial 2 Cremation 3 Removal from State Consulton 5 Other (Specify) 20b. Place of Discemetery, competery, competery, competers, comp							o. 1	3-2005	Rrantw	od M	m
a	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Ser	vice Licens	999	/	22	. Name and	d Addres	s of Facili	John	son and	Jenkin	is Fur	eral Home
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b	/Medical Examiner		resulting in death)		Due to (or as a conse	quence bf):		i			10			
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Вох	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnan	2	23c. If yes, outo	ome of pregn		Ectopic pre	gnancy					te of delive	•
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		e Cc	25. Was case referred to me	dical								1 ☐ Yes 2	No		2□ No
Viita	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No		lospital:	patient 2	ER/Outpatien	3 DO	Othe	r		(Check only on		(5)	
	g Phy erthi		27. Manner of Death		28a. Date of	f Injury	28b. Time of		c. Injury Work	4 LI NU		ne 5 Reside)
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	To the Hos within 24 h To the Fun completely	Med	one) 29b. Signature and title of ce		and manne	er stated.			License						
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			1 - For State Registrar	State of Marylan		rtment of F		Mental Hy	/gien	1000	2 7 549
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, La O Aa. Facility Name 4f not institution, give	V.	<u> </u>	4b. City, Town, o	U r Location of Deal	2. Date of D. Month	st.	57	as Time of Death
	Funeral Director		Usual Residence of Decedent	OLINS HOP ex 7. Age (In Vs. I M 2 P 33	ast birthday) Yrs.	Funder 1 Year Months Days	If Under 24 Hrs Hours Min.				. Birthplace (State or Foreign Country) VIETNAM
	the Marylan 28a-f show octificatist	ector	10a. State 10b. County VIRGINIA LOUDOU 10e. Street and Number		, Town or Loca TERLING						10d. Inside City Limits
-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or Iteme 23e or 28e-f show or other treumatic event, the Medical Evanting must be notified at	ed by Funeral Director	45412 GABLE SQ. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	11	20164 as Decedent of H Yes, specify Cube Yes 2 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	VI.	Black, Specify:	American Indian, White, etc. ASIAN
21215-0036	filed within 72 Hygiene. other than "ne ent, the Medic	Completed	(Specify only highest gra	College (1-4or 5+)	(Give ki life. De	mis usual Occup ind of work done of NOT use retired	during most of wo i)	rking		Kind of Busin	ess/Industry
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Baltimore, Mar	t. Pa ntmen rtent;		19a. Informant's Name/Relationship (: LEUYEN VO—WIFE 20a. Method of Disposition 1 (XBurial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify Company) 1. Signa (company)	Removal from State NATIO	45412 ace of Disposi ametery, crema DNAL ME	GABLE SO tion (Name of trory or other place MORIAL F		ING, VA	20 20c.	164 Location - Cit	y or Town, State URCH • VIRGINI
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	death certificate be executed Medical e attending physician and e attending physician and d for use as the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis Due to (or as a consequence) Due to (or as a consequence) C. End St Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	liver	dise	92v			5 days 5 days 2 months 3 months
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ō	ng Phye fter this meral dii	atlon; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Satural 5 Pending investigation	28a. Done of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	3 DOA Other	4 🗆 Nursing n	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			Specify)
	o ii fe	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify)				City or To	wn, Stat	'e)	r Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	one)	vsician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death o on and/or inves	stigation, in my op	inion, death occu	rred at the time,	date an	d place, and	due to the cause(s)
/	with To Con	<	29b. Signature and title of certifier	n le	MD	29c. License	9-000			-	onth, Day, Year)
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es.	Sta Registr	-	31. Date filed (Month, Day, Year) AUG 0 9 2005	32. Registrar's Signatu	Smell						

DHMH 17 Rev 1/2001

			1 - For Stata Ragistrar	State of Maryla		artment of H			ene 005	27650
	Physic /Medi		Decedent's Name (First, Middle, Last, Fred	Holmes	Worle	у		2. Date of Death Month August		3. Time of Death 7:20 P. _M
	Exami		4a. Facility Name (If not institution, give Vindobona Nur			4b. City, Town, or Brad	Location of Death	hts	4c. County of Death	rick
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Security Number 224-14-8224	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Dec . /,	9. Birth Cou	nplace (State or Foreign unity) Virginia
	Maryland I-f show	tor	10a. State 10b. County Virginia Smythe	10c. C	ity, Town or Lo Saltvi					10d. Inside City Limits 1 ☐ Yes 2 ☐ Xio
	th with the 23s or 28s	ai Direc	10e. Street and Number 2384 Saltville H	ighway		10f. Zip Code	24370	10g	g. Citizen of What Cou	
9800	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any highty or other traumatic event, it a Modical Examinar must be notified at 2008.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 □ X/Yes 2 □ No if Yes, Give □ Dec Year or Dates.	1945 to	I□Yes 2√2 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
21215-0036	d within 72 l gione. er than "nati	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	Inte. I		ation furing most of workin ent Operat	ng	Sb. Kind of Business/Ir Constructi	
Maryland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) James F. Worle				18. Mother's Name			
	and 2 sh ealth and n 27 la m		19a. Informant's Name/Relationship (Ty Fred H. Worley, Jr	./Son					Tity or Town State Zi	
Baltimore,	nit. Pages 1 artment of Hi ortant: If iter injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens	emoval from StateSmitl	risiburg**					irg, MD.
Ba	permi Depa Impo any ir		tukard C.	C. Justin	3,-	106 Fas	& Basford	Street.	Frederick	MD 21701
}	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	even	al Vesc	-la- Ac	ci deut	'	Interval Between Onset and Death
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8760, <	ficate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
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Vita	Phyaician: The Is this certificate har ral director, page 2	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2] ER/Outpatient	3□ DOA Othe	26. Place of Death	(Check only one)	e 6 ☐Other (Specif	
Division of	ding P	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how		7)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)	eet, factory, office	2	Bf. Location (Stree City or Town, S	t and Number or Rura State)	I Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	edical	29a. Certifier 1 Cartifying Physical Check only one) 2 Madical Examin	ician: To the best of my kno ar: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	e, date and place, ar inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due to	lated. the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	MP		29c. License	2203		Date signed (Month, 8-17:	
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended items 17, 18, 20a,b, Cftificate of Death per fh/wichel/86-15-057dls 2. Date of Death 1. Decedent's Name (First, Middle, Last) 82 AM **Physician** LLIAMS 05 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Regional Medical Center 1 Under 24 Hrs. NICOMILO Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7-28-22 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕦 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No ALISBURZ Director Mi 10 DMIC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or 801 BOURNE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 4 Divorced 3 ☐ Widowed "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LABDRER 18. Mother's Name (First, Middle, Maiden Sumame) بالملغ 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any fully or other traumatic event 2008. Ganzia Williams Roberta Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ER 119 - JUSTICE AVE.

20b. Place of Disposition (Name of CONK)

cemetery, crematory or other place) MD 21801 DALIS BURY JOHNSON ARETAKER ATHY 20c. Location - City or Town, State 20a. Method of Disposition Date Delmar, DE 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 17-2005 Salisbury, MD BENNIE Smith Funeral Hore Delmarva Crematory 8-17-2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 917-W. ISABELLA ST. SALISBURY, MA 2190, in Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** openham /Medical Due to (or as a consequence of): Examiner Due to (or as a donsequence of) Sequentially list conditions, it amy load to in immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an varuilar disease Sec autopsy performed 2 No 2E No 1 Yes this certificate scizure disorder 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28c. Injury at Work? completely filled in by the tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 5 Pending Natural 1 Yes 2 No death. investigation or Attend after death Director: / 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of acrofier

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month,

Jo mus

32. Pojistrar's Signature

Peninsula

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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CPM 05-05189 REGINALD

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Phys /Me Exa

Baltimore, Maryland 21215-0036

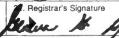
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eral ctor		578-76-2807	Sex 7. 1 ★ 2 ☐ F	Age (In yrs. I	last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)		place (State or Foreign ntry) DC		
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t be notified		10e. Street and Number 1921 Ridge	Place,	S.E.		10f. Zip Code 200 2	20	1	0g. Citizen of U.S.		ntry?		
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or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park 20c. Location - City or Town, State 8/13/05 Riverdale, Md.											
Injury e	-	4 Donation 5 Other (Speci 21. Signature of Funeral Service Lice		K1				13/05	Kiver	аате	., ма.		
any Ir		1/4 / X	1111		<i>a</i>	22. Name and Addre	SS OF FACILITY						
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Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who completed cause of Piemelle E. Scithall, M.)

31. Date filed (Month, Day, Year)

AUG 1 0 2005



right of the state of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

August 03, 2005

			1 - For State Registrer	State of Mar			Health and	Mental Hyg	-	
	Physici	an	1. Decedent's Name (First, Middle, Las Mary Elizabet	,				2. Date of Deat		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat		4c. County o	f Death
	Funeral Director		5. Social Security Number 247-34-4454 1 Usual Residence of Decedent	ex 7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days		8. Date of Birth Oct.	⁴ 1927	9. Birthplace (State or Foreign Country) SC
	e Maryland 3a-f show Illfed at	ctor	10a. State 10b. County MD Charl	ł .	Oc. City, Town or Lo LaPlat					10d. Inside City Limits 1 XYes 2 □ No
	3a or 24	al Dire	10e. Street and Number 101 Wesley Dr.	Apt. 303		10f. Zip Code 20646	5	10	g. Citizen of Wr USA	
980	d within 72 hours atter death with the Maryland liene. I than "natural", or Items 23a or 28a-f show The Medical Exer, Irett-rest be incilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🕬 Vidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		- American Indian, White, etc. White
Maryland 21215-0036	l within liene. r than "	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire UUTSE	pation during most of wor ad)	rking	6b. Kind of Bus	iness/Industry
yland	be do do	To Be (17. Father's Name (First, Middle, Last) B.E. Campbell				Ruby	ne (First, Middle, N Teat Ca	mpbel1	
, Mai	nd 2:		19a. Informant's Name/Relationship (Ronald Walters)					ıral Route Number, 18by, Md		
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, creat MD Vet.	osition (Name of matory or other pla Cemeter	ce) 8/12/	Date 2 2 C		ity or Town, State ham, Md.
Balt	permit. Pag Department Important: h any injury o		21. Signature of Funeral Service Licen	Eled	MOO945	P.O. Bo	x 567 I	FUNERA aPlata,	MD 206	,PA 46
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aSop	haxal (er the mode of dyin	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
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	p ag ig is	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	ne Hospital 124 hours a ne Funeral I	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemption (Check only one)	rsicien: To the best of miner: On the basis of example and manner stated	amination and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occur	and due to the cau rred at the time, dat	se(s) and mann e and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Illas		29c. Licens	e number 10419	290	1. Date signed (I	Month, Day, Year)
B	B3		30 Name and address of person who o	ompleted cause of death		rles St	La Plata	MD 206	46	
	Sta Registra	-	31. Date filed (Month, Day, Year) AUG 0 9 2005	32. Registrar's	Signature Appen					

			1- For State of Maryland /		artment			and M	ental Hy	gien Reg. N		~ ~ ~ ~	
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Mildred Marguerite Weed 4a. Facility Name (If not institution, give street and number)		4b. City.	Town or I	Location o	of Death	2. Date of De Month August	eath D	ay Year	3:55 A	M
	Funeral Director	161	St. Mary's Nursing Center 5. Social Security Number 6. Sex 1 M 2 XF 90	irthday) Yrs.	Leon	ardt		24 Hrs.	8. Date of Bi (Month, Di	rth ay, Year	St. Mary		oreign
	ne Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Too Maryland Charles Hugh									10d. Inside City L 1 ☐ Yes 2 5	imits
	eath with the same same or 2	erai Dire	15156 Hughesville Manor Drive	1401	10f. Zip	20	637			U	itizen of What Co S A		
9600	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show to Medical Evertinet must be nettlind at	d by Fun	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ Or Dates:		Was Decede f Yes, spec 1 ☐ Yes 2		panic Orig , Mexican, Specify:	in? (Spe , Puerto F	cify Yes or No Rican, etc.))- 	14. Race - Ame Black, White Specify:		
Maryland 21215-0036	od within 72 l giene. er than "nati i tre Medica	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10	(Give life. L	dent's Usual kind of work DO NOT use USEWI	k done du e retired)	ion uring most	of working	ng		(ind of Business/	Industry	
yland	should be filed and Mental Hygis markad other umatic event, I	To Be (17. Father's Name (First, Middle, Last) Clarence Coombs				Lill	ian	(First, Middle Brough	, Maidei	n Sumame)		
	and 2 shi lealth and m 27 is m						11e M			er, City Hug	or Town, State, 2 hesville	(ip Code) ,MD 2063	7
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Examiner must be nutified at ance.		20a. Method of Disposition 1	H il	1 Ceme Name and	etery Address	y A	ug. Bri	nsfiel	05 S	ocation - City or Suitland :		ıe,
68/60,	Medical Examiner bhysician and sthe burial-transit sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libease or injury that initiated events resulting in death) Last Due to (or as a consequence d. Due to (or as a c	of):	The mode	of dying,	such as c	eardiac or	respiratory a	rrest,		Approximate 0 of Interval Between Onsein and Death Onsein	622
C. BOX	the death certific by the attending p ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pre Other (spe						23d. Date of deliv	very Day Year	
cords, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting i	n the un	derlying car	use given	in Part I.					the cause of death	
Vital Reco	The la ate has page 2	e Completed	25. Was case referred to medical				% Place o	of Death /	24a. Was autop perfo 1 Yes	rmed? 2 2 No	prior to co	opsy findings availa impletion of cause 2 No	able of
0	ding Phys h. After this funeral di	ation: To B	1 ∰Natural 5 □ Pending (Month, Day Year) I 2 □ Accident investigation	utpatient Time of Injury		Other: c. Injury a Work?	4 Nurs	sing Home		lence	6 ☐ Other (Speci ry occurred	fy)	
Š	To the Hospital or Attsnding within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Certificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)			_			City or Tow	m, State			
	thin 24 ho ithin 24 ho the Fune ompletely fi	Medical	29a. Certifier (Check only one) 1	dor inve	estigation, in	the time, n my opin License n	ion, death	place, an occurred	at the time, o	date and	place, and due t	o the cause(s)	
	F ≯ F 8		30. Name and address of person who completed cause of death (Item 23a)	11	1) (>64	19		8-	9-05	vay, rear)	
N	35 Sta	le.	James P. jarboe, M.D. 24035	Thre	ee No		Rd.	Но	11ywo	od,1	MD 2063	16	
	Registra		AUG 1 0 2005	1	perk								

			1 - For Registrar	State of M	arylan	-	artmen rtificat			and M	lental Hy	giene Reg. No	000-	27650	***
I	Physici	an	Decedent's Name (First, Middle, Last HARVEST RUSSELL	•							2. Date of De Month	eath Da	y Yea	3. Time of Death)
1	/Media	cal	4a. Facility Name (If not institution, give		·		4h City	Town or	Location o	of Death	8	40	. County of De	1 1 1 1	.W
	Examir	ier	Prince George's Co				'	verl		, Dout.			ince G		
	Funeral	П	Social Security Number 6. Se	TM OFF		last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir	rth	9. B	irthplace (State or Foreig	gn
	Director		248-36-0640 Usual Residence of Decedent	88 102 88	3	Yrs.					11/18/	1910	Co.	Lumbia, SC	_
	ryland how		10a. State 10b. County			y, Town or Lo								10d. Inside City Limit	
	Ba-f s	ecto	MD Prince Ge	orge	Seat	Pleas								1 Yes 2 N	0
	with t	ā	10e. Street and Number 521 68th Place				10f. Zip					USA	tizen of What (Country?	
	death	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	1		ispanic Orig	gin? (Spe	acify Yes or No Rican, etc.)	nerican Indian,			
36	or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give			1 🗆 Yes		Specify:	, rueito	nican, etc.)	nite, etc. a.c. ¹ c			
21215-0036	2 hour	ed b	15. Decedent's Edu	Year or Dates:		16a. Dece	dent's Usua	al Occupa	ation			16b. K	ind of Busines	s/Industry	
215	thin 7;	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Chef. 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Chef.								of work	ng	•			
121	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be neithed at		17. Father's Name (First, Middle, Last)	2		ciieii			18 Mothe	r'e Name	(First, Middle		. Gov't	•	
and	ld be f ental h ked of	To Be	Harvest Williams								a Thom				
Maryland	2 shou and M Is mar	-	19a. Informant's Name/Relationship (T	γρe, Print)							l Route Numb			Zip Code)	
	1 and 1 Health Sm 27		20a. Method of Disposition		20h B	521 6			e,Sea		easant,		20743	y Taura State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,		Ced	emetery, crer ar Hill	natory or o Cemete	ther place	os	3/11/2			land,MD	or rown, State	
altir	permit. F Departme Importan any injur		21. Signature of Euneral Service Circus			22	2. Name an	d Addres	s of Facility	y Ceda	er Hill I	Tunera	al More,	Inc.	-
<u>m</u>	8 9 E 8		John 7/3al	el-							Guitland,		20746	7,	
	Pnysician		23a. Part J. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each l	ine.				_	cardiac d	r respiratory a	irrest,		Approximate interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence ol):	11	ha."	1						
		Jer	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	b. Oliva to (or da	a ounsequ	i citte	176	700.74							
	cate be executed by sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		(-)150	5								
8760,	be exician a contract		rosulting in County East	Due to (or as	a consequ	uence of):									
687	ificate g phys as the	edlc		d								- 21			
30X	eath certific attending pl I for use as t	an/M	230. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pr	egnancy					23d. Date of d		
O. B	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown			Other (sp						Month	Day Year	
ď.	es that the de igned by the a be detached to	by Ph	Part II. Other significant conditions co	ntributing to death t	out not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco u	use contribute	to the cause of death?	
ords	w require: been sig should b										1 🗆	Yes 2	□ No 3 □ F	Probably 4 Unknows	n
Records,	e lawr has be je 2 sh	Completed									24a. Was	psy	24b. Were a	autopsy findings available completion of cause of	le
aiF		e Cor	25. Was case referred to medical								1 Tes	2 No		s 2 No	
f Vital	S S	To Be	examiner?	lospital:	ent 2	ER/Outpatien	t 3 DC)A Othe	ar		<i>_(Check only o</i> ne 5□ Resi		6 □Other (Sp	ecify)	
27. Mann: f Death 28a. Date of Injury at Work? 27. Mann: f Death 28a. Date of Injury at Work? 28b. Time of Injury at Work?									_						
Division	deati deati ctor: / the	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	iury - At ho	me larm str	M eet factor		Yes 2□N	-	28f Location /	Street an	d Number or F	Rural Route Number,	_
Di		Certification;	4 Homicide determined	building, e	c. (Specify	1)	oot, taolory	, omco			City or To			iarai riosto rambor,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ner: On the basis o	it examinat	wledge, death	occurred restigation.	at the tim	e, date and	d place, a	and due to the ed at the time.	cause(s)	and manner a	as stated.	
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner st	ated.			. License		-				nth, Day, Year)	
	⊢ <i>s</i> ⊢ ö		▶ K	rent	-			3	537	0	3	Q	12/1	25	
R	2		30. Name and address of person who of TS10N BERMAN	mpleted cause of a	death (Item	23a) (Type,					mp	20	1785		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 9 2005	2. Registr	rar's Signal	ture	2			-					
					A	1910									

			1 - For 8-9-05 Registrar/Amend #23a 1. Decedent's Name (First, Middle	State of	Marylan	nd / Depa	artment o	of He	ealth a Death	and Me	ental Hy	/gien	00	00	2	
Ç	Physic		Donald Afficial	e, Last) Dav			illiams				2. Date of Do Month Lugust (eath	av	Year	1:15	Death M
	/Medi Examii		4a. Facility Name (If not institution Holy Cross Hospi		er)		4b. City, To Silver						c. County	of Deeth		n
	Funeral Director		5. Social Security Number 334–22–6012	6. Sex 7.	Age (In yrs. 74	last birthday) Yrs.	If Under 1 \ Months C	Year Days	If Under 2 Hours	Min. Au	8. Date of Bi (Month, D Igust 24	rth ay, Үөа i , 19	30	9. Birthp Cour	lace (State ntry)	or Foreign inois
	e Maryland ta-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County D.C.			y, Town or Lo								1	0d. Inside (City Limits s 2 □ No
	th with th 23a or 28 Let be no	al Director	10e. Street and Number 3218 11th Place S	S.E.			10f. Zip Co					10g. C	itizen of V USA	What Cour	itry?	
920	be filed within 72 hours after death with the Maryland nat hygiene. Identify than "natural", or Itema 23a or 28a-f show event, the Markeal Examirer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3√√√ Widowed 4 □ Divorced	12. Was Decede Armed Force ied 153Yes 2 If Yes, Give Year or Date	ss? □No194	/-	Was Deceden f Yes, specify 1 ☐ Yes 2√√x		panic Orig , Mexican, Specify:	jin? (Spec , Puerto R	ify Yes or No ican, etc.)	0.		e - Ame <i>ri</i> ck, White,		ζ
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4)	or 5+)	(Give	dent's Usual C kind of work of DO NOT use r iesel Me	done du retired)	ring most	of working	7			usiness/Indust	,	
/land 2	2 should be filed and Mental Hygi Is marked other raumatic event, I	To Be Co	12 17. Father's Name (First, Middle, Ohlan Wi	Last) 11iams					18. Mother	's Name ('First, Middle				<u>.1 y</u>	
, Mar	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relations Denise R. Williams				g Address <i>(S.</i> interthu		d Number	r or Rural i	Route Numb				Code)	
imore	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (S		ite C	emetery, cren	sition (Name of natory or other) 1. Ceme	r place)		Da:				city or To		
Bal	Depart Import any in		21. Signature of Funeral Service	los f			. Name and A 5160 Oxo:	n Hi	11 Roa	ad Oxor	rge P. 1 n Hill,	Kalas Mary	Fune	ral Ho	ome P.A	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	SPIRAT as a consequ	ORY FA				ardiac or I	respiratory a	rrest,			Approxima Interval Be Onset and	tween
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):												
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcor 1□Live birth 4□Pregnant 9□ Unknown	2 Fetal at time of de	death 3	Ectopic pregn Other (s <i>pecif</i>						23d. Date Mor	e of deliver	*	Year
ords, P	w requires that been signed t should be deta	by	Part II. Other significant condition Metasta			ulting in the ur	derlying caus	e given	in Part I.						e cause of cably 4 🔀	
Vital Records,		Completed									24a. Was autor perfo 1 Yes	rmed?	pd	rior to con eath?	osy findings apletion of c	available cause of
Division of Vit	ding Phys	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 宋\lambda \rightarrow \rig			ER/Outpatient 28b. Time of Injury	28c.	Other: Injury a Work?	4 🗌 Nurs	sing Home	Check only o	dence			ŀ	
Divis	. 0 2 -	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory, of	fice		28f	f. Location (S City or Tox	Street ar vn, State	nd Numbe a)	ar or Rural	Route Num	iber,
	To the Hospital or within 24 hours aftr To the Funeral Discompletely filled in	Medical	one) Medical	Physician: To the be xaminer: On the basis and manner	of examinat	wledge, death ion and/or inv	estigation, in r	ny opin	ion, death	place, and occurred	due to the at the time,	cause(s date and	and mar d place, a	ner as sta nd due to	ited. the cause(s	3)
	J. S. C. S.		29b. Signature and title of dertifier	X					umber 2885			8 Da	e signed	(Month, D	ay, Year)	
2	(10)		30. Name and address of person v Sonya Wych	e MD 150	00 For	est Gl	Print) en Road	d Si	llver	Spri	ing, M	ary1	and.	20910)	
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 0 9 20	005 Person	strar's Signat	ure Some	le le									

DHMH 17 Rev 1/2001

				eartment of Health and Meretificate of Death					
	Q.		1. Decedent's Name (First, Middle, Last)		Date of Death 3. ime of Death				
	Physici /Medi		mee Loure wong	A	ugust 6, 2005 14; 30PM				
	Examir			4b. City, Town, or Location of Death	4c. County of Death				
			2220 Quail Creek Ct.	Bel Air	Harford				
	Funeral Director		5. Social Security Number 222-26-2012 Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 78 Yrs. 78	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. Ju	Date of Birth (Month, Day, Year) WY 5, 1927 9. Birthplace (State or Foreign Country) DE				
	72 hours affer death with the Maryland natural', or liams 23a or 28a-1 ahow ilical Examinat must be toylifled at		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits				
	Mar-fat	ģ	DE New Castle Wilming	nton	1 ☐ Yes 2 X No				
	th the or 28,	ire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
	ath wi	Funeral Director	1512 Harvey Road	19810	USA				
	ar deg	nei	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.				
36	s afte	by Fi		1 ☐ Yes 2 ☐ KNo Specify:	Specify: Oriental				
8	hour tural			edent's Usual Occupation	16b. Kind of Business/Industry				
15	nin 72 n "na Medir	Completed	(Specify only highest grade completed) (Give life.	e kind of work done during most of working DO NOT use retired)	Tob. Aird of Business/Industry				
212	e filed within Il Hygiene. other then " vent, the Mes	E	Elementary/Secondary (0-12) College (1-4or 5+)	of Employed	Laundry				
p	be filed within 72 hours after death with the Marylan Ital Hygiene. sd othar than "natural", or liams 23a or 28a-f ahow othar, the Medical Exantine met neather routified at	Bec	, ∤ 17. Father's Name <i>(First, Middle, Last)</i>	18. Mother's Name (Fi	rst, Middle, Maiden Sumame)				
ylai	should be nd Mental marked a	2	Louie Fat Bik	Leung					
Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Important: if itam 27 is marked any injury or other traumatic e once.				oute Number, City or Town, State, Zip Code)				
	and lealth im 27 her tu			2 Harvey Road, Wilm					
Baltimore,	iges if its or ot		Abdital 2 Cientation 3 Pentovalitoni State	osition (Name of Date matory or other place)	20c. Location - City or Town, State				
哥	it. Pa rtmer rtant njury			emetery 08-14-2	2005 Newark, Delaware				
Ba	permi Depa Impo any i		21. State of the last service Liberises	22 West Main Street,	Foard and Jones, Inc. Newark. DE 19711				
	rate be executed / Medical and physician and the buriat-transit the buriat-transit than the buriat-transit than the buriat-transit than the buriat-transit than the buriat-transit than the buriat-transit than the buriat-	Examiner	23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate naise. Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Com cap	spiratory arrest, Approximate Interval Between Onset and Death Lumber 5				
P.O. Box 68760,	death certific e attending p id for use as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year				
	ires that signed k d be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
Ö	w requir been si should	etec			7				
Vital Records,	2 as 2	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No				
	sicia certi	o Be	25. Was case referred to medical examiner? 1 \(\sum Yes 2 \) \(\sum No \) Hospital: 1 \(\sum Inpatient 2 \) ER/Outpatier	26. Place of Death Ch	design to				
The invalidant 2 literature of the invalidation of the invalidatio									
DIVI	taf or Att s after de al Diract	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, str building, etc. (Specify)		ocation (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attanding Is within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and ovestigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)				
	To To 1	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
•			I formas, MD	115314	August 8, 2005				
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, # Farkas, Mi) Sasans, world	Print) Less Chesapake,	Lospice, Elliton, MD				
	Sta Registr	te ar	31. Date filed (Month Pay Year) 0 2005 32. Figistrar's Signature	bade, 1	-,-,				

			1- For State of Maryland / Dep Registrar Ce	eartment of I		and Me		iene	5 27658
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Ruby Ethel Akers				2. Date of Dea USUST 2	20, Day 2005 Ye	3. Time of Death 8:42 AM M
	Examir		4a. Facility Name (If not institution, give street and number) 5501 Shookstown Road	4b. City, Town, o		of Death		4c. County of D	
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Days	If Under	24 Hrs. 1 Min.	B. Date of Birth OCL •		Birthplace (State or Foreign Villiginia
	Maryland e-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Frederick Frederick Frederick 10c. City, Town or L 10c. Cit	ocation CK					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28 81 be not	Funeral Director	10e. Street and Number 5501 Shookstown Road	10f. Zip Code 21702			1	0g. Citizen of What U.S.A.	Country?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examinal must be notified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origan, Mexican Specify:	gin? (Spec l. Puerto R	ify Yes or No- ican, etc.)		merican Indian, /hite, etc. nite
Maryland 21215-0036	d within 72 h giene. Ir then "natu	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occup e kind of work done DO NOT use retire semother	oation during most d)	t of working	7	16b. Kind of Busine School/E	-
land	should be file nd Mental Hyg i markad otha umatic evant,	To Be C	17. Father's Name (First, Middle, Last) James C. Snead					Maiden Sumame) eth Fitzg	
	and 2 shou ealth and N n 27 Is ma		19a. Informant's Name/Relationship (Type, Print) Anne A. Boyer, daughter 19b. Maill 5501	ng Address (Street Shooks to	and Numbe	ad, F	Route Number rederic	City or Town, State	e, <i>Zip Cod</i> e) 702
Baltimore,	Pages 1 annent of Heannt: If itam		20a. Method of Disposition ✓ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	osition (Name of matory or other plan vet Ceneter	y Au	Da 1g. 24,		20c. Location - City Frederic	or Town, State k, Maryland
Balti	permit. Departm Importa any inju			²Keeneydda 106 East	nd Bas Churc	sford ch St	PA Fur reet, F	eral Homo rederick	e MD 21701
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		ng, such as	cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and physician and st the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate course. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):						
O. Box 6	ath certif ttending or use as	by Physician/Media		□Ectopic pregnancy □ Other (specify)	′			23d. Date of Month	delivery Day Year
Records, P.	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause giv	en in Part I.				to the cause of death? Probably 4 Junknown
		Completed	J.				24a. Was ar autopsy perform 1 Yes 2	/ prior t	
of Vital	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Oth			Check only one Reside		Decify)
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DIVIS	tel or Atta s after de al Directo ed in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		28	f. Location (Str City or Town	eet and Number or State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat. 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	n occurred at the tin vestigation, in my o	ne, date and pinion, death	l place, and h occurred	d due to the ca at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier MTI-Ce WO	29c. Licenso				d. Date signed (Mo	
17			30. Name and address of person who completed cause of death (Item 23a) (Type,	. 1	1610	0	2170		-,
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 4 2005	i de la companya de l	V	Ni -			

			1 - State Registrar	te of Maryland / Departme <i>Certifica</i>	nt of Health and Me te of Death	ental Hygier	0.0.
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) Shirley 4a. Facility Name (If not institution, give street a	Ajello	y, Town, or Location of Death		Year 9. Time of Death 12.13 A M
	Funeral Director		5. Social Security Number 6. Sex 219–26–6206 1 M 2		of 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea May 26,19	9. Birthplace (State or Foreign Country) MD.
	the Maryland 28a-f show	rector	10a. State 10b. County MD. Baltimore	10c. City, Town or Location Middle River	ip Code	100 (10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country?
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examiner must be nullified at	Funeral Director	18 Holcumb Court 11. Marital Status 12. Wa Arm 1 Never Married 2 Married 1	s Decedent Ever in U.S. 13. Was Deceded Forces? 14. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	1220 edent of Hispanic Origin? (Spececify Cuban, Mexican, Puerto R	U	SA 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	vithin 72 hours ne. han "natural", e Medical Exa	Completed by	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col	16a, Decedent's Us (Give kind of w life, DO NOT	rork done during most of working use retired)	9	SpecifyWhite Kind of Business/Industry
ryland 2	12 should be filed wit n and Mental Hygiens 1s marked other th: raumatic event, Ire	To Be Co	12 years 17. Father's Name (First, Middle, Last) Robert MacDonald	Housewi	18. Mother's Name (Ellen Eva	(First, Middle, Maide	
altimóre, Ma	Pages 1 and 2 sinent of Health and the fittern 27 is rint; if item 27 is rint or other traur		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remova	ughter 18 Holcu 20b. Place of Disposition (N cemetery, crematory of	other place) Augus	le River,	MD. 21220 Location - City or Town, State
■ Baltin	permit. Pages Department of Important: If it any injury or o		23. Part 1 Enter the disease of complications	mully 22. Name Conne	Jesus Cem. 20, 20 Addrass of Facility Ly Funeral Hon Sollers Point Fode of dying, such as cardiac or	ne Of Duna Road, Duna	dalk,Md. 21222
8/60, <	'Amedical / Medical / Medical / Medical Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or Injury that initiated events c.	e on each line.		respiratory arrest,	Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as	hysician/Med	in the past 12 months?	as, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic Pregnant at time of death 5 Other (s			23d. Date of delivery Month Day Year
ecords, P	w requires that the de been signed by the a should be detached f	by P	Part II. Other significant conditions contributin	g to death but not resulting in the underlying	cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
итаі жес	The la ate has page 2	Be Completed	25. Was case referred to medical examiner?		26. Place of Death (24a. Was an autopsy performed? 1 Yes 2 N Check only one)	24b. Were autopsy findings available prior to completion of cause of death? o 1 Yes 2 No
on or	ling Phys n. After this funeral dii	ertification; To	Natural 5 Pending 2 Accident investigation	M	28c. Injury at	d. Describe how inju	
2	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical Certifi	4 Homicide determined 29a. Certifier (Check only) Medical Examiner: On	Place of Injury - At home, farm, street, facto building, etc. (Specify) To the best of my knowledge, death occurred the basis of examination and/or investigation	at the time, date and place, and	City or Town, Stat	and manney as stated
	To the within 2 To the comple	Med	29b. Signature and title of certifier	29)-54736		ate signed (Month, Day, Year)
	Sta Registr		30. Name and address of person who completed of the state	d cause of death (Item 23a) (Type, Print) Compared to the first state of the compared to the	ware srive,	Baltir	nore, M. J. 21237

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death **Physician** Black Laurice 2005 Annie /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Oeath **Examiner** aryland If Under 24 Hrs If Under 1 Year 5. Social Security Number Funeral 6. Sex (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Country Months Hours Min. 1 ☐ M 2 🗓 F Yrs 71 Director 238-50-3912 03 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-1 ehow other traumatic event, the Macdical Examinar must be notified at 1 Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1520 West North Ave Funeral 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced and Mental Hygiene. Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic Worker <u>llth grade</u> na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clora Newkirk Thomas Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: if item 27 is ony injury or other tra 4001 Primrose Ave, Baltimore, Md Cheryl Lathan-Daughter itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Randallstown, Md King Memorial Park 8/25/05 21. Signature of Fundal Service Licensee March F/H West any ir 4300 Wabash ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, nmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o ð 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Ţ 1 🗌 Yes this Oate of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28c. 28d. Describe how injury occurred After 5 Pending investigation 1 Natural s after death. M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certification 29c. License number 29d. Oate signed (Month, Day, Year) ted cau Name and as 32. Registrar's Signature State AUG 2 Registrar

			1 - For State Registrar	State of Maryla	-		of Health of Death		, ,	jiene	U.E.	0766.
Ž.	Physici	22	1. Decedent's Name (First, Middle, Last,)					2. Date of Dea Month	th Day	Year	3-Time di Dean
	/Medic			Elverta L.	Brown				August	18 2	200	2:46 pM
	Examir	ıer	4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	wn, or Location	of Death		4c. County	of Death	
198			5. Social Security Number 6. Sec	7. Age (In yrs.	last hirthday)	If Under 1 Y	far If Under	Sec.	9 Date of Birth		0. 0:45	(0)
Ţ	Funeral Director			M 2∑F 87	Yrs.		ays Hours	Min.	8. Date of Birth (Month, Day 9-16-		9. Birthpi Coun	lace (State or Foreign try) N.C.
	yłano		10a. State 10b. County		ity, Town or Lo	cation					10	Od. Inside City Limits
	a-f-s	Director	Md N/A	. F	Balto							XXYes 2 □ No
	ith th	Oire	10e. Street and Number			10f. Zip Co	de		1	0g. Citizen of \	What Coun	try?
	ath w	rail	2125 Ashburton St			2	1216			USA	1	
	er de	Funeral		12. Was Decedent Ever in t Amed Forces?	J.S. 13. \	Was Decedent f Yes, specify	t of Hispanic Or Cuban, Mexical	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		e - America ck, White, e	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "nature!", or itema 23a or 28a-f show or other traumatic event, it e Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 21X No If Yes, Give Year or Dates:		l⊡Yes 2 <mark>/</mark> ∏	No Specify:	:		Specify	Bla	ack
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2	within ene. then "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use n	lone during mos etired)	SE OF WORK!	ig			
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Maryland 21215-0036	lid be fillental Hrked ot	To Be	17. Father's Name (First, Middle, Last) James Somerville				_	_{ers Name} urtne	(First, Middle, I		10)	
J.	2 should be and Mental Is marked (aumatic ev	F	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	q Address (St			Route Number		State. Zip	Code)
	1 and 2 Health a tem 27 is		Adrianne Carter -	Granddaughte								,
ore,	of Her of Her item		20a. Method of Disposition		Place of Disport	sition (Name o	of r place)	D	ate	20c. Location -	City or To	wn, State
<u>m</u>	Pages nent of I ant: If its ury or o		1 ∏Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-		ial Pk 8	8-23-	2005	Arbutu	ıs, Mo	1
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signatura of Funeral Service License	Xele	22	Name and A	ddress of Facili			West Balto,	Md 21	1215
(a) (b)			23a. Part . Enter the disease, or compli shock, or heart failure. List only or	ications that caused the dea	th. Do not ente	or the mode of	dying, such as	cardiac oi	respiratory arri	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sansis							(Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):	-					,	2/1/3
	Examiner		Sequentially list conditions,	Vincey	Tract	Inf	action)	DAYS
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
	and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a consec	Juence of):							
8760,	icate be executed physician and s the burial-transit				(10/100 01).							
687	phys s the	dic		1								
Box (certii nding use a	/W	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn.						23d Dat	e of deliver	24
m.	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c		Ectopic pregn Other (specify				Mor		Day Year
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ŝ	ires that the death certific signed by the attending p d be detached for use as		Part II. Other significant conditions con	ntributing to death but not res	sulting in the un	derlying causi	e given in Part I					e cause of death?
ord	w requir been si should	Completed by	Hypertension						1 🗌 Ye	s 2 L No	3 Proba	ibly 4 🖺 Unknown
Sec.	e law	npie.							24a. Was ar autops	24b. V	Vere autop	sy findings available apletion of cause of
<u>e</u>	cate								perform 1 ☐ Yes 2	ned? c	leath?	2 🗀 No
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ō	Phys r this ral di	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ⊋Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of		4 140		e 5 ☐ Reside 8d. Describe ho			1
ion	nding tth. :: Afte e fune	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐ I		od. Dosonbo no	w injury occurr	ьч	
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Ö	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.			1								
	Hos 24 ho Fun e Fun letely 1	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination Control on the control on the	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death ition and/or inv	occurred at the estigation, in r	ne time, date an my opinion, dea	id place, ai th occurre	nd due to the ca d at the time, da	iuse(s) and ma ite and place, a	nner as sta ind due to i	ited. the cause(s)
	To the Within 2 To the complet	Me	29b. Signature and title of certifier	1 -2		29c. Lic	cense number		25	d. Date signed	(Month, D	Pay, Year)
	-		15	1000	MO	00	275-	7	A	veira	19.	2005
A	1/		30. Name and address of person who co				^		Baltin			
	Sta	to	31. Date filed (Month, Day, Year)	32. Redistrar's Signa) Cut	500	HVR	Y	saltin	noce)	MD	21229
	Sta Registra		AUG 2 4 2	32. Redistrar's Signa	M. A	nation						

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F		, ,	ene . N2 () () 5	27662
	Physic		Decedent's Name (First, Middle,	Last)	//	2		2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution,	give street and number)	<u> </u>	4b. City, Town, o	r Location of Death	august	19 Scos 4c. County of De	ath
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I	Funeral		,	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		irthplace (State or Foreign Country)
	Director		212-34-6768	1□ M 2X)F	74 Yrs.	July 5	110013	6-8-31		N.C.
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation	· · · · · ·			10d. Inside City Limits
	Man,	ţō	Md. N	A	Balti	more				Yes 2 □ No
	h the or 28s	Director	10e. Street and Number		****	10f. Zip Code		10g	. Citizen of What C	Country?
	23a c	a D	3030 Harford	Road		2	1218		USA	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f ahow other traumatic event. If a Maryland Examinating the notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Am Black, Wh Specify: B	ite, etc.
5-0	72 h	etec	15. Decedent's (Specify only highest		(Give	dent's Usual Occup	during most of wor	kina 16	b. Kind of Busines	s/Industry
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<u>ılan</u>	Aental Aental rked c	To Be	Hero	F	errell		Grad		Nunn	
lar,	2 should and Men is marke sumatic		19a. Informant's Name/Relationship					ral Route Number, C		
	and lealth m 27 her tr		Gracie Nedd	Daughter			ford Roa	d, Baltim	ore, Md.	21202
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		:	sition (Name of matory or other place nat.	·		Baltimore	
Ball	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Li	w and		Name and Address		Balti 1101 E	more, Md North	. 21202 Ave.
	Physician /Medical		23a. Part1. Enter the disease, or construction of the construction	a a a. h	he death. Do not ent 		g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
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	nsit	Examiner	Cause (Disease or injury	Due t ∉ 	consequence of):					
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687	tificate I g physi as the b	edicai		d						
P.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SUNo 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
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Vital Records,		Completed						24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of s 2 \(\sum \) No
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o		F 1.	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	P	28c. Injury Work		me 5 Residence 28d. Describe how i		cify)
ion	등 는 < 글	atto	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		Year) Injury		? ′es 2 □ No		,,	
Division	s after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injur building, etc.	y - At home, farm, stre (Specity)	eet, factory, office		28f. Location (Stree City or Town, S	and Number or R ate)	ural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of e	xamination and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occuri	and due to the cause ed at the time, date	e(s) and manner as and place, and due	s stated. a to the cause(s)
) _	Tot com		29b. Signature and title of certifier	do o	W/S	29c. License	0354	63 Ac	Date signed (Mont	9,2005
1	NV		30 Name and address of person wh	completed cause of dea	ith (Item 23a) (Type, F	Print) Jot	worth	picins l	Joshien Balti	~ 21207 more
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	at a				
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death **Physician** Month 8 Day Clara Brown 2005 20 0200 М /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4814 Parkside Drive Baltimore NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□M 3€ F 230-44-7529 79 Director Yrs 10-30-25 ٧a. Usual Residence of Decedent death with the Maryland 10a. State 10h Count Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, It e Modical Examiner must be matified at 10c. City, Town or Location 10d. Inside City Limits Director Y☐Yes 2☐No Md. NA Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4814 Parkside Drive 21206 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes X☐ No Specify. Black 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Domestic Other Peoples Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maddox Frank Sallie Tisdale 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frankie Brown Son 4814 Parkside Drive, Baltimore, Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Depirtment o Important: If any injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. 8-29-05 Owings Mills, Md. * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 wan March F.H. East 1101 E. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of) Examiner PANTANSINA 16 your CARDIOVASCULA Sequentially list conditions, in any, teauning to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death Month Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate ! 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of After Injury at Work? 28d. Describe how injury occurred 1, Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Dey, Year) llans 10661 211) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH CAUGUT BALTIMONE STRALI. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:07 LESLIE H. BECKER 4ngust 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ROSSVILLE FRANKLIN WOODS NURSING HOME If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** 1 × M 2□ F Dec. 2~1921 Maryland Director 215~12~5833 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b County or 28a-f show the Medical Examiner must be notified at 1 Tes 2 No Baltimore County Directo Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a (21234 USA 3319 Putty Hill Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 □ No If Yes, Give WW 11 Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married ※☑ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) BG & E. Electric Testman 12 yrs. 5 yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If itam 27 Is markad oth Elizabeth Mullhausen William Henry Becker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3319 Putty Hill Avenue Baltimore, Md. 21234 f Health itam 27 I Ruth B. Becker (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ita any injury or otl 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9-2-2005 Baltimore, Md. *4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 21. Signature of Funeral Service Licensee 7401 Belair Rd. Baltimore, Md. 21236 Q -Ø 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Nle tasta **Physician** cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ₽ robably 4 □Unknown P Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 Q-N6 26. Place of Death (Check only one) 25. Was case referred to medical examiner Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2 - No ၉ this 28d. Describe how injury occurred Certification:

death.

Division of Vital Records, P.O. Box 68760, Hospital or Attanding after death Diractor: 24 hours a To tha tha

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28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

knowsford Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin 9/05

31. Date filed (Month, Day, 2005 4

32 Aegistrar's Signature

DHMH 17 Rev 1/2001

Medical

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Registrar

			1 - For State Registrar	State of Marylan		artment of h		•	giene Reg. No?	5 27665
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1215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. It of ther then "natural", or teme 23e or 28e-f show of other then "natural", or teme 25e or 28e-f show event. It's Modical Examirer must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give life. L		oation during most of wor d)	king	16b. Kind of Busin	
Maryland 21	0 - 0 5	Be	6 yrs. 17. Father's Name (First, Middle, Last) Michael Andrelezu	N/A	Ηοι	usewife			Housekeep Maiden Sumame)	oing-Own Home
	12 sh sh and 7 Is rr treum	2	19a. Informant's Name/Relationship (Ty Gloria Ruddock (D	pe, Print)	1.			ral Route Numbe	er, City or Town, State	
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<u>א</u>	or the nospitel or Attending within 24 hours after death. To the Funerel Director: Attencempletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	2Be. Place of Injury - At hor building, etc. (Specify,	·)			City or Town	n, State)	Rural Route Number,
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0	/ /		30. Name and address of person who co	n Arenve		rint)	e M) 2	1224	
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	2		30. Name and address of serson who	completed cause o	f death (Item	1 23a) (Type,		<u>, , , , , , , , , , , , , , , , , , , </u>	10			3/10/		2	
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year George K. Berberich, Sr. 20, AUGUST 2005 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 309 Rossiter Avenue Baltimore N/A5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**X**M 2□F Months Days Hours Min. 218-01-8013 Yrs Director 88 AUG 13, 1917 Maryland Usual Residence of Decedent with the Maryland 10b. Count 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Rossiter Avenue death Funeral 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 1 Never Married 2X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer <u>Mechanical</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony Berberich Anna Fertitta 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum. 2005. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nannette Berberich/wife Date 2°c. Location - City or Town, State 309 Rossiter Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State Metro Crematory, Inc. * 4 ☐ Donation 5 ☐ Other (Specify) 8/22/05 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Dawn F. 299 Frederick Road Baltimore, MD 21228 McDonald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No Completed 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 🗆 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Magner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide filled in 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGERY MD Ker 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 4 2005 Registrar

	For State Registrar	State of M		partment of H	lealth and Mer Death	ntal Hygien	0000	07660
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ire, Maryic	19a. Informant's Name/RIERIC BROWN 20a. Method of Disposition	(SON)	41 20b. Place of Di	9 MOSHER	Date	ALTO, M	or Town, State, Zip ID. 212 Location - City or To	17
Page Page nent o ant: If ury or		mation 3 Removal from State Other (Specify)	9	crematory or other place IEMORIAL 22. Name and Addres CALVIN B	PARK AUG.			MD.
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Examine		4a. Facility Name (If not institution, give	e street and number)	. 4	4b. City, To	own, or Location of Death		4c. C	ounty of Deat	1 1
		5. Social Security Number 6. S		yrs. last birtho	day) If Under 1	Year If Under 24 Hrs.	urnie		thre	Hounds
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DHMH 17 Rev 1/2001

Please Type or Brint in Black Indelible Inko Fnsure All Copies Are Legible. Jesus Lopez Cardenas State of Maryland / Department of Health and Mental Hygiene 2 05-5611 State Registrar AKG Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First Middle, Last) Month nav **Physician** 19, denas August 2005 8:13 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2304 Noonham Road Windsor Mill Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours N/A Yrs. Mexic Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Tewn or Location 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Nun 10f. Zip Code or Items 23a or Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11, Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 XYes 2□ No Baltimore, Maryland 21215-0036 Specify: Mexican Specify: ģ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens. Important: if Item 27 is marked other than 'na any injury or other treumatic event, Ita Made. (Give kind of work done during most of working life. QO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Be ဥ Informant's Name/Relationship (Type, Pi 19b. Mailing Address (Street and Nu 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 □Removal from State 21. Signature of Funeral Service Ligensee Services 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** Sharp /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ъ Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? 1X Yes 2 🗆 No funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $4 \square \text{ Nursing Home}$ 5 \square Residence 6 $\square \text{Other}$ (Specify) at SCENE 1√Xes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification; After Subject stabled and but himself Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 XNo Found 7:30 within 24 hours after death. To the Funeral Director: A 2/19/05 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide 2364 Noonham Rd. home Windsor Mill, To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 CKMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.EAugust 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 2

20082. Registrar's Signature

4

Penn Street, Baltimore, Maryland 21201

AEM # 05-05659 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wayne Edward Corson State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** CORSON. August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 122 South Conkling Street 8. Date of Birth (Month, Day, Year) Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. 8 irthplace (State or Foreign Country) **Funeral** Days Hours 2/2-34-133 66 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-1 ehow 1 Pres 2 No Completed by Funeral Director MD Imore 10e. Street and Number 10g. Citizen of What Country? ONKling 122 USA street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc. 11. Marital Status 1 Des 2 No Korean If Yes, Give Year or Dates: War 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No WhiR Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance it of Health and Mental Hyg if item 27 is marked other or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any lighty or other traumatic event, SIDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ ORSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WayNEE. COISON, JR 20b. Place of Disposition (Name of cometery, crematory or other place) MD Veryue, Bo 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DAYVICW 05 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ashton Funeral Home adley Dring ,110W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etweer Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No Yes 2 □ No Yes To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ∑ Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 6 DOther (Specify) Scene 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Found Diss 1 Natural 5 Pending investigation death. 21/05 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours efter To the Funeral Dire residence Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME August 22,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn St. Baltimore, Maryland 21201

State Registrar

THE ODORE Miking 31. Date filed (Month, Day, Year)

NS 2 4 2005

32. Registrar's Signature

		4	For	State of Marylan						
	_		State Registrasmend item 1. Decedent's Name (First, Middle, Las	#8 oer fh g847	9/069	THICATE OF	Death	2. Date of Dea		3. Time of Death
Phys /Me	icia dica	il -	Eric Campbel					Month 08	21 2	^{Year} 005 9:29p ^M
Exar	nine	r	4a. Facility Name (If not institution, give				or Location of Dea	ath	4c. County o	or Death
Funer	al		5205 Elmer Ave 5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hr	n. (Month, Da	th y, Year)	9. Birthplace (State or Foreign Country)
Direct	or	-	217-02-4859 Usual Residence of Decedent	62	Yrs.			MAY 2	8,1943	Jamaica
yland how			10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Ba-fs		Funeral Director	MD n	/a	Balt	imore 10f. Zip Code			10g. Citizen of Wi	
with t			10e. Street and Number 5205 Elmer Ave	nuo			215			
death		nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.			(Specify Yes or No orto Rican, etc.)	14. Race	- American Indian, , White, etc.
ING Z I Z I 35-U030 be filed within 72 hours after death with the Maryland tal Hygiene. and other than "natural", or items 23a or 28a-f show event, it wegine Examination in the market of the marke		by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	Jamaican
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TC CICI		် ပ	12th 17. Father's Name (First, Middle, Last,) 1.	l lv	lason	18. Mother's N	ame (First, Middle,		Construction
a de la pa		To Be	, , , , , , , , , , , , , , , , , , , ,	unk				Campbel		
MEALY IAIN 12 should be th and Mental 7 Is marked (traumatic av			19a. Informant's Name/Relationship (Туре, Print)			t and Number or I	Rural Route Numbe	er, City or Town, S	State, Zip Code)
2 D = C -		Ν	lethlyn V. Camp 20a. Method of Disposition	bell/wife _{20b.I}	5520	Price	Ave.,	Balto.	MD 2121	5 Dity or Town, State
nor ages ant of little if it it			1 V Burial 2 Cremation 3 C 4 Donation	Removal from State		sition (Name of matory or other pla	!	31 05		200
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other	once.	-	21. Signature of Funeral Service Licer		Julawi	Name and Addre	ess of Facility W	ylie F/	H P.A.	ore, MD of Balto.Co.
n 8855	8		Montario	MANY) 92	00 Libe	erty kd	.,Randa	llstown	, MD 21133
			23a. Par J. Ent r the "Leas", or com shock or heart failur List only Immediate Cause (Final	one caus on each line.						Interval Between Onset and Death
Physicia /Medic	_		disease or condition resulting in death)	a. Due to (or as a cons	ue/ce of):	Ker	1910	iseuse	_	
Examin	80		Sequentially list conditions.	. Hype	rter	bion				
led led		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or is consec	quence of):					
execuin and inal-tran		Examiner	that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):					
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that the ed by the detache		Phys	9 Unknown	9□ Unknown			iven in Cont I	22a Did :	obacco uso contri	bute to the cause of death?
Fords, P.O. BOX 68 requires that the death certifical been signed by the attending plantould be detached for use as a		þ	Part II. Other significent conditions	contributing to death but not re-	suiting in the u	inderlying cause gi	ven in Panti.			3 Probably 4 Unknown
ecords, law requires that been signed as been signed.		Completed						24a. Was	an 24b. W	Vere autopsy findings available
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Of VITAL Physician: rthis certification and director and	.	2 2	1 ☐ Yes 2 No 27. Manner of real	28a. Date of triury	28b. Time o	III SLI DOA	al intermediate	Home 5 X esi	dence 6 Othe how injury occurre	
Vitending I death.		ation	1 X Natural 5 Pending 2 Accident investigation	(Month, Day Year)	tnjury		ork? ∃Yes 2□No			
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DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director. After this certific		0	29a. Certifier Certifying P	hysician: To the best of my kn	owledge, deat	th occurred at the t	ime, date and pla	ice, and due to the	cause(s) and mar	nner as stated.
ha Ho in 24 h he Fu		edical	one)	miner: On the basis of examin and manner stated.	ation and/or in			curred at the time,	1	
To 1		Σ	29b. Signature and title of certifier	11001		29c. Licen	ise number	1	29d. Date signed	(Month, Day, Year)
	,		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)	2701	7	40	90)
	1		Eddye Bull	bck MD 4	120 A	atterso	n Ave	enve I	saltimo	SIEIZGH AND
	Sta	te	31. Date filed (Month, Day, Year) ALIC 2 4 2	32. Registrar's Sign	nature	F. 1.				

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 (1 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0	
***	Physici /Medic		Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 08 18 2005 10.25	P M
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	Funeral Director		Journal Section Secti	_
	e Marylan 8a-f ehow utilied at	ctor	Oa. State 10b. County 10c. City, Town or Location 10d. Inside City Rary and NA Baltimore 10d. Inside City Towns or Location 10d. Inside	
	sath with the s 23e or 2	Funeral Director	0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
036	ours after de el', or item Examinari	þ	1. Marital Status 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NUTSING HOW	10
Maryland 2	buld be filed Mental Hygid arked other attc event,	To Be Co	7. Father's Name (First, Middle, Last) Robert A. Holmes Bessie Ross	10
	1 and 2 should Health and Men iem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11. Jay Cauthorne 1617 N. Warwick Ave. Batto Md. 213	116
Baltimore,	Page nent c ant: If ary or		20b. Place of Disposition 1 Sevinal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee	1d.
Ba	Dermit. Departr Imports any Inji		Joseph L. Russ Funeral Home P. A. 2222 W. North Ave. Baito. Md. 21216 23a. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between	tu
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Explain.	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
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. Box 68	ath certifica ttending ph for use as th	Physician/Medi	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 1 Yes 2 No 9 Unknown 9	ear
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I Records,		Completed	24a. Was an autopsy findings a autopsy performed? death? 1 Yes 2 1 No 1 Yes 2 No	variable use of
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Division	i ji e	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	er,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
,	To the comp	W/	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/18/05	
7	11/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR R MADIANAN / 377 CINDEN AVENUE, RALTIMORE MD 71201	
4	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
DH	IMH 17 Rev 1/2	001	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Irene Lorraine Caldwell 2005 10:35 A M August 19, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Rossville Rosedale If Under 1 Year If Under 24 Hrs. exp. 81 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/6/1919 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Months Days Hours Min. Pennsylvania 205-10-2404 86 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at MD N/A Baltimore 1⊈Yes 2 No Director 8.08/06/1918 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21206 6816 Everall Avenue or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: by Specify: White 3 ₩ Widowed 4 Divorced "naturei", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, tra Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Carpet Company Clerical 10 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Richwine Phoebe Roof 2 -2404 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6816 Everall Avenue Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type, Print) Joyce Derr/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of faith 8/23/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 9 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 205. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) syndrome \mathcal{F} **Physician** /Medical Due to (or as a consequence of): **Examiner** S Sequentially list conditions, aux. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consequence of: Due to (or as a consequence of): Box 68760, ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. Physi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No Caldwell, certificete 1 Yes 2 No After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Delatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

Division of Vital Records, or Attending Physician: I Director: / within 24 hours after To the Funerel Direct

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7842

4 2005

Dakwood Rd Ste 100 Colon Burnie, 40

Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

Medical

4 Homicide

Chardon 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner OLUMB If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 12–4–55 ial Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Davs Hours 49 Director 220-58-1477 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other treumatic event, the Medical Examinar must be nutified at Director N☐ Yes 2 No Glen Burnie Md. Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 239 Woodhill Drive 21061 Apt. B USA 238 death v Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "neturel", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. Dialysis Nurse Bon Secour Hosp. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) iit. Pages 1 and 2 should be ortiment of Health and Mental ortent: If item 27 le marked o Charles Carrington Nora Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Nora Dawson Mother 7975 Crain Hwy., Baltimore, Md. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cem. 8-19-05 njury (Lansdowne, Md. *4 ☐ Donation 5 ☐ Other (Specify) permit.
Deportra
Importe
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 7 la 1101 E. North March F.H. East) anne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\subseteq \text{No} \) certificate 2 No 1 Yes Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check in one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of De ti 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeref Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

ANG 2

d cause of death (Item 23a) (Type, Print)

strar's Signature

32. F

VERNON DORSETT Rallimore Maryland 21215-0036

		•	For State Registrer	State of	Marylan				lealth : Death		ental Hy	giene Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of Dea Month August	ath Day	ZUU!	3.7 ime/of Death
	/Medic Examin		Vernon L. Dorset 4a. Facility Name (If not institution, given 12320 Belair Roa	e street and num	ber)				or Location	of Death	August	4c.	County of Deat	h
F	Funeral Director		5. Social Security Number 6. S		. Age (In yrs. 97	last birthday) Yrs.		r 1 Year	If Under Hours	Min.	8. Date of Birt (Month, Da) 07/25/	h y, Ye <i>ar)</i>	9. Birt	hplace (State or Foreign buntry) h Carolina
	Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	with the Asa or 28a-1	Funeral Director	MD Baltin		KI	ngsvi]	10f. Zi	p Code	- 				izen of What Co	puntry?
920	be filed within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Mudicul Evant are must be recitied at	ठ	12320 Belair Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced	ces? 2 <mark>⊠</mark> No	.S. 13.	Was Dece	edent of I	Hispanic Or an, Mexica	in, Puerto	ecify Yes or No Rican, etc.)		S.A. 14. Race - Ame Black, Whit Specify: W	
21215-0036	na na	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-	4or 5+)	life.	dent's Usi kind of w DO NOT	ork done use retire	during mos	st of worki	ing		ind of Business	Industry
Maryland 2	2 should be filed withir or and Mental Hygiene. Is marked other than raumatic event, the M	To Be C	17. Father's Name (First, Middle, Las Ivey Dorsett 19a. Informant's Name/Relationship						Lo	uise	Myers	Maiden	_	
	1 and 2 s Health ar sm 27 is ther trau		Anna K. Dorsett 20a. Method of Disposition 1 □ Burial 2 X Cremation 3	(wife)	tate	12320 Place of Disponentery, cre	Bel osition (Na matory or	air ame of other pla	Road	- Kir	ngsvill Date	20c. Lo	laryland ocation - City or	21087 Town, State
Baltimore,	permit. Pages Department of H Important: If Ite any in Jury or of		4 □Donation 5 □ Other (Special Service Light) 21. Signature of Funeral Service Light		Me	2	2. Name a	and Addr	ess of Facil	lity E.	F. Las	sahn	Funera Maryl	, <u>Maryland</u> 1 Home, P. <i>R</i> and 21087
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ea	CDX) Or as a conseq	١	ter the mo	ode of dy	ing, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death heurs
0,	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. a	or as a consequence of as a consequence of as a consequence of as a consequence of a conseq	quence of):		-						years
68760,	tificate be ig physicia as the bu	ledical	•	Cd 4x.	nply	ema								years
P.O. Box	The law requires that the death certific the has been signed by the attending F page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ∏ Feta antat time of c	al death 3	⊒Ectopic (у				23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	ed by Pł	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the I	underlying	cause g	iven in Part	1.		obacco (Yes 2		o the cause of death?
Il Records,		Completed									24a. Was autor perio 1 \(\text{Yes}		prior to death?	utopsy findings available completion of cause of 2 10 No
Vital	ting Physician: The n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2] ER/Outpatre	ent 3 🗆 🗈	OA O	hor	e of Deatl lursing Ho	me 5 X Resi		6 □Other (Spe	ocify)
Division of	fter fter	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	on	of Injury h, Day Year) of Injury - At h ng, etc. (Speci	28b. Time (Injury)	М		Yes 2]No	28d. Describe 28f. Location (: City or To:	Street ar	nd Number or Ri	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 12 Certifying F (Check only one) 1 Medical Ex-	Physicien: To the particle of the barriage and mann	sis of examina	owledge, dea ation and/or i	th occurre	d at the ton, in my	time, date a opinion, de	ind place, eath occurr	and due to the red at the time,	cause(s date an	and manner as d place, and due	s stated. e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	e Elyl	±W.		2		se number			29d. Da	te signed (Mont	th, Day, Year)
(5	2	30. Name and address of person wh		of death (Itel 9524	m 23a) (Type Bela		Ed	BA	ICT,	MD 2	212	36	
	St	ate	31. Date filed (Month, Day, Year)	A/	egistrar's Sign	ature	paste	.9		,				

			1 - State Amend Item	State of Mary 26 per Dr., C	and / Dep 846,08/	artme 2470 irtifica	nt of H odhb ite of L	ealth and I Death			005	27677
	Physicia	an l	1. Decedent's Name (First, Middle, Las	-					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Margaret A.Dela						July	24	2005	12:30A M
	Examin	C1	4a. Facility Name (If not institution, give				•	Location of Death	1	4c. C	ounty of Death	
			437 Anglesea St 5. Social Security Number 6. Se		yrs. last birthday	_	Ltimo er1Year	if Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign ntry)
	Funeral Director		217-34-7271	JM 2 ∑ F	68 Yrs.	Month	s Days	Hours Min.	1 – 09	_{ly, Year)} -37	MD	intry)
-	5		Usual Residence of Decedent									
	anylan show	_	10a. State 10b. County		c. City, Town or L							10d. Inside City Limits 1 Yes 2 No
1	8a-f	octo	MD	E	Baltimo		71 Onda			10a Citiza	n of What Cou	
3	S Or 2	Ö	10e. Street and Number				Zip Code 21224	ı			ITO WHAT COU	may:
	ns 23	era	437 Anglesea St	12. Was Decedent Ever	in U.S. 13				pecify Yes or No	USA 14	. Race - Amer	ican fndian,
999	permit. Pages 1 and 2 should be filed within 72 hours after death with rhe maryland. Department of Health and Mental Hygiene. Department if firm 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, I' a Medical Evarialist must be notified at QDCs.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Nivorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			2 No	ispanic Origin? (S in, Mexican, Puert Specify:	o Rican, etc.)		Black, White pecify Whi	
0000-0	natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	(Giv	e kind of t	sual Occup work done o	durina most of wor	rking	16b. Kind	of Business/Ir	ndustry
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ם פ	Hyg othar	a)	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle			
yland	Jid be Aenta rkad tic ev	To B	Vincent Lombard					Julia I	Derosa			
Mary	and N		19a. Informant's Name/Relationship (7	•		•		and Number or Ru		-		p Code)
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baltimore,	ges 1 t of H If ita or otl		20a. Method of Disposition 1 Burial 2 Cremation 3		Ob. Place of Disp cemetery, cr						ation - City or T	
	it. Pa rtmen rtent: njury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 					ory 7-2				
n n	Depa Depa Impo any i		21. Signature of Pullar Service Citient	1/1				ern Ave	-			
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		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown		Other					MORUI	Day
J.	that the	Phy	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlyin	a cause div	en in Part I.	23e. Did	tobacco_us	e contribute to	the cause of death?
Hecords,	S F 9	d by	, and a significant and a sign			,	3 3		1 🔄	Yes 2□	No 3 ☐ Pro	bably 4 Unknown
COL	w require been sign should t	Completed							24a. Wa		24b. Were aut	opsy findings available
Ä	The lav	dwc							auto perf	opsy ormed? 2 100	prior to c death? 1 \(\sum \text{Yes}	ompletion of cause of
		a)	25. Was case referred to medical					26. Place of De	ath (Check only			20110
	S D	To B	examiner?	Hospital: 1 Inpatient	2 ER/Outpati	ient 3	DOA OU	er: 4 🗌 Nursing I	Home 5 XRes	idence 6	□Other (Spec	ify)
	ng Ph Iter th ineral		27. Manner of Death 1 Delatural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injury	/	28c. Injur Wor		28d. Describe	how injury	occurred	
<u> </u>	Attending in death. actor: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not b		A1 hama (a	M		Yes 2 No	29f Location	(Street and	Number or Ru	ral Route Number,
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	Hospita 4 hours Funaral tely filler	Medical C	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	ysician: To the best of miner: On the basis of example and manner stated	amination and/or	ath occurr investigat	ed at the tir	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) a , date and p	and manner as blace, and due	stated. to the cause(s)
	vithin 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number			signed (Month	, Day, Year)
1			1 hajaben	1			DS.	3070		7/2	-7/05	
- 1	V		30. Name and address of person who					1.20				
0			31. Date fifed (Month, Day, Year)	39. Registrar's	Signature A	C , 1	uD.	-1231				
	Sta Regist	ate	AUG 2. 4.20	05 Fine and	D. A.	ange						

DHMH 17 Rev 1/2001

Margaret A. Dalancey

	For Sta	ate of Maryland / D	epartment of Health	and Mental Hy	giene			
	1 - For State Registrar		Certificate of Deatl	h	Reg. No O	27670		
	Decedent's Name (First, Middle, Last)			2. Date of De	aath CUU	(2. Time(a) Death()		
Physician	Alma C	. Eldrid	σe	August	Day Year 17 2005	6:39 PM		
/Medical	4a. Facility Name (If not institution, give street		4b. Cily, Town, or Location		4c. County of Dea			
Examiner						rundel		
	Baltimore Washington 5. Social Security Number 6. Sex	7. Age (In yrs. last birt		or 24 Hrs 0 Date of Di	db 0 Bi-			
Funeral	104		rs. Months Days Hours		ay, Year) Co	thplace (State or Foreign puntry)		
Director	Usual Residence of Decedent	44 00		0-14-	1911 Ma	1 y 1 anu		
and	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits		
ahc sho	Md. AACO	Corro	70.70			1 √ Yes 2 No		
Be-f		Seve	1°11 10f. Zip Code		10g. Citizen of What C	ountry?		
Mith t	10e. Street and Number							
15-0036 In 72 hours after death with the Maryland naturel; or liems 23s or 28s-f show redical Exercitivat be notified at sletch by Funeral Director	687 Queenstown	Road Vas Decedent Ever in U.S.	21144		USA	nicen Indian		
r de	A A	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	an, Puerto Rican, etc.)	Black, White, etc.				
036 urs afte	1 Never Married 2 Married 1	Yes 2 No Yes, Give 'ear or Dates:	s 2XI No Give 1 ☐ Yes X☐ No Specify:			lack		
DO:					16b. Kind of Business/Industry			
21215-00 ed within 72 hou yejishen "naturu ine rheal "naturu ine rheal "naturu Completed	15. Decedent's Education (Specify only highest grade con	n 16a. n <i>pleted)</i>	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost of working	166. Kind of Business	d or Business/Industry		
121.	Elementary/Secondary (0-12)	college (1-4or 5+)			O II			
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land 21 land 21 d be filed wental Hygier ked other tit c event, Its o Be Cor	17. Father's Name (First, Middle, Last)				, Walderi Sumame)			
VIa Neurikan Men Men Men Men Men Men Men Men Men Me		rley			Burley			
Maryland 21215-0036 Maryland 21215-0036 To should be filed within 72 hours aft and Mental Hygiene. 27 is marked other than "naturel", or recumatic event, the Medical Exercit To Be Completed by F	19a. Informant's Name/Relationship (Type, F	Print) 19b.	Mailing Address (Street and Num	ber or Rural Route Numb	oer, City or Town, State,	Zip Code)		
re, Maryland 212 re, Maryland 212 s 1 and 2 should be filed withit free at 1 smarked other than other treumatic event, the Maryland other treumatic event, the Maryland other treumatic event, the Maryland ev	Regina A. Kelly	Sister 7	68 Queenstowr	Road, Sev	ern, Maryl	and 21144		
of Hee	20a. Method of Disposition	20b. Place of cemeter	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or	Town, State		
mor	1 Burial 2 Cremation 3 Remove	St.Re	st Cemetery	8/23/05	Hanover,	Md.		
	21. Signature of Funeral Service Licensee	2	22. Name and Address of Fac	5-C-16: 1-C-17				
Balt Balt Departit Import	Clamb m.	Intero	Estep _E Broth	rs Funera	l Ser, B.A	17		
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the death. Do r	not enter the mode of dying, such a	as cardiac or respiratory	arrest,	Approximate Interval Between		
	shock, or heart failure. List only one ca Immediate Cause (Final	luse on earch line.	The Street	,		Onset and Death		
Physician /Medical	disease or condition resulting in death)	Jeg.		K		homs		
Examiner		Due to (or as a consequent	or):					
	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):					
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and and I-tran	that initiated events c resulting in death) Last	Due to (or as a consequence	of):					
58760, ficate be executed physician and stree burial-transit edical Examil								
68760, ificate be ex g physician as the buria	d							
K 6	IF FEMALE:	f yes, outcome of pregnancy			and Date of de	li		
Box 6 Box 6 Beath certifi attending 1 for use as	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death			23d. Date of de Month	Day Year		
be de ned for sed for	1 Yes 2 No	4□Pregnant at time of death 9□ Unknown	5 Other (specify)					
P.O. Box at the death certified by the attending etached for use a Physician/M	9 _ ORKHOWN	Alaman danah basa asa sasa Misa i	the made thing on the part in Day	41 230 Did	tobacco use contribute	o the cause of death?		
S, es the est the be de de de de de de de de de de de de de	Part II. Other significant conditions commod	rul or Di	the underlying cause given in Fai					
Record The law requir The law sequir The las been s age 2 should		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
awr awr s be 2 sh	Dimentia			24a. Wa	opsy prior to	24b. Were autopsy findings available prior to completion of cause of		
Rhe I The I age				per	formed? death? 2. No 1 ☐ Ye			
tal an:] an:] cor, p	25. Was case referred to medical		26. Pla	ace of Death (Check only				
Viriect direct	examiner? 1 ☐ Yes 2 🔁 No	ital: 1 Manpatient 2 ER/Ou	tpatient 3 DOA Other: 4	Nursing Home 5 Res	sidence 6 Other (Sp.	ecify)		
Phy Phy Trithis and c			28d. Describe how injury occurred					
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isi kten deal deal ctor: y the	3 ☐ Suicide 6 ☐ Could not be 2	8e. Place of Injury - At home, fa	rm, street, factory, office		(Street and Number or F	Rural Route Number,		
Division of Vital Records, P.O. Box tell or Attending Physician: The law requires that the death cer is after death. el Director: After this certificate has been signed by the attending of in by the funeral director, page 2 should be detached for use Certification: To Be Completed by Physician/N	4 Homicide	building, etc. (Specify)		City or 10	own, State)			
pital pours	29a. Certifier 1 P Certifying Physicia	n: To the best of my knowledge	e, death occurred at the time, date	and place, and due to the	e cause(s) and manner a	is stated.		
the Hosp thin 24 hou the Fune impletely fill	(Check only 2 Medical Examiner:		d/or investigation, in my opinion, d					
Division of Vital Records, P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a Medical Certification: To Be Completed by Physician/Me	29b. Signature and title of certifier		29c. License numbe		29d. Date signed (Mor			
6 4 \$ 4	1 Malayr	12	D-4	1520	8/17/200.	5		
,	1000		(Timo Brint) 7 % C LA	1	D-100 C-14	208		
	30. Name and address of person who compl	eted cause of death (Item 23a)	(Type, Film) $\sum Z \sum P C$	Burnio,	1/10 - 21261	000		
7	31. Date filed (Month, Day, Year)	32. Registrar's Signature	you	iourno,				
State Registrar	511C 0 4 200E	() b	hack's					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monthus **Physician** EPSIEIN 4c. County of Deeth /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner BALTIMORE PIKESVILLE RUXTON PIKESVILLE NURSING HOME If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) AUG. 18,1905 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🙀 F PA 100 340-01-5399 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **Worle** 1 ☐ Yes 2 No tism 27 is marked other than "naturel", or iteme 23a or 28e-f ehov other traumatic event, the Mudical Examinational be notified at BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 7 SUDBROOK LANE Race - American Indian, Bleck, White, etc. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married WHITE Specify: Specify: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Nidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION SUBSTITUTE TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be should be I (UNOBTAINABLE) **JACOBSON** SARAH SAMUEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 st ment of Health and cent: If Item 27 is 1 15610 MOORPARK STREET #6 - ENCINO, CA 91436 SHAYLE RAY / NEPHEW 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD ARLINGTON CHIZUK AMUNO 8/23/2005 permit. Pege Department of Important: If eny injury or once. * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 proximate erval Batween at a Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. East Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760 attending physicien Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 JUnknown APD Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Beath (Check only one) or Attending Physician: 25. Was case referred to medical examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who complete death (Item 23a) (Type, Print ltteman 31. Date filed (Month! Da State Desta Registrar

Box 68760,
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Records,
of Vital
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		State of Maryland / Department of Health and Certificate of Death		tal Hyg	jiene	egibii	ð.	
Physicia /Medica	al∝	1. Decedent's Name (First, Middle, Last) ETHEL LEE FAIR	A	Date of Dea Month	Day	200	5	7:10 PM
Examine Funeral Director	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De Saltmore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wonths Days Hours Mi	y Irs. 8.1	Date of Birth Month, Day) 4 / 1 6		N/A	Birthplace	a (State or Foreign
*natural", or items 23a or 28a-f show	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE CITY					10d.	Inside City Limits ↑ Yes 2 □ No
		10e. Street and Number 10f. Zip Code 3904 DUVALL AVENUE 21216		1	-	en of Wha	t Country?	,
		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Pu 14. Was Decedent of Hispanic Origin? 15. Was Decedent of Hispanic Origin? 16. Yes, specify Cuban, Mexican, Pu 17. Yes 2 No Specify:	(Specify erto Rica	Yes or No- n, etc.)		4. Race - / Black, V Specify:	American I Vhite, etc. BLA	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH 16a. Decedent's Usual Occupation (Give kind of work done during most of will life. DO NOT use retired) CUSTODIAL/JANITO			STA'	of Busine FE & ERNM	FED	ERAL
		17. Father's Name (First, Middle, Last) RASTUS FAIR 18. Mother's Name (First, Middle, Maiden Sun JENNIE GILLIAM						
s 1 and 2 should Health and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) FANNIE M. DAVIS / NIECE 20a. Method of Disposition 19b. Mailing Address (Street and Number or 3904 DUVALL AVE.		ALTIM	ORE		212	16
Page: ment o ant: If ury or		**Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	26/0)5	BAL	TIMO	RE C	
Physician		23a. April the rease, or complications that caused the death. To not enter the mode of dying, such as card former ate Cause (Final disease or condition resulting in death) a. Anoxic brain former aterms as a card former aterms as a card former aterms as a card former aterms as a card former aterms as a card former aterms as a card former aterms as a card former at the mode of dying, such as card former at the mode of dying, such as card former at the mode of dying, such as card former at the mode of dying, such as card former at the mode of dying and a card former at the mode of dying at th	EIG	ITS A	VE,		TIMO	
es that the death certificate be standard by the attending physicis be detached for use as the burk by Dhysicisal	Physician/Medical Examiner	Due to (or as a consequence of): Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					7	d.,
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of deli			delivery Day	y Year
	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e. Did tobacco use contribute to the cause of dea			
	Completed				med?	24b. Were prior deat	to comple h?	findings available etion of cause of
Physiciar this cartif	: To Be	25. Was case referred to medical examiner? 26. Place of E		Specify)				
Attending death. ctor: After y the funer	Certification:	1 Senatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Colud not be determined to the columns of the colum	28f.	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,				
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F3F8		P() (VI SMD RES-000				sust 19,2005		
81		30. Nam And add s I person to completed cause of death (Item 23a) (Type, Print) Andrew A. Nelso, Mis Sirai Hospitel of	Ba	Itimor	re			
Sta Registra	100	31. Date filed (Month, Day, Year) AUG 2 4 2005						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month Year 00005 4c. County of Death 4b. City, Town, or Location of Death

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, bive street and number) Examiner Baltimore HOS er If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6.9ex 1 M 200 7. Age (In yrs. last birthday) lace (State or Foreign **Funeral** Days 219-21-8378 Usual Residence of Decedent Trs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Director brylan 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0712) Pages 1 and 2 should be filed withlinent of Health and Mental Hygiene. College (1-4or 5+) onema 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Hoyd 19b. Mailing Address (Street and Number or Rural Route Number, (ty or Town, State, Zip Code) 221 SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: if ite any injury or of cemetery, crematory or other place) 3 Removal from State 1 Deurial 2 ☐ Cremation ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of F cility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** Due to (or as a consequence of): disease or condition Years resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to min ediata cause. Enter Underlying Cause (Disease or injury Examiner Dira to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification; To Be Completed by Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Floyd

31. Date filed (Month, Day, Year)

Hospica

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

Registrar

			1 - For State Registrar		State of Ma	ryland /		artment <i>rtificate</i>				giene Reg. No.	005	27682	
	Physicia		Decedent's Name (First, JO		st) H .			Gau	ıse		2. Date of De Month	Day	Year 2005	3. Time of Death - 12:09 PM	1
	/Medic Examin		4a. Facility Name (If not ins			. 1		4b. City, T	own, or Loc	ation of Death	0.8	-	ounty of Deat	h	_
			Good Samo	irita				0	timo						
ľ	Funeral Director		5. Social Security Number 214–62–7035		ex 7. Age	(In yrs. last	Vrs.	If Under 1 Months		ours Min.	8. Date of Bird (Month, Da	h y, Year) 9–53	9. Birt	hplace (State or Foreign untry) S.C.	n
	land ow		Usual Residence of Deceder 10a. State 10b. C			10c. City, To	own or Lo	cation						10d. Inside City Limits	
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	h the	Funeral Director	10e. Street and Number		114			10f. Zip C				10g. Citize	n of What Co	untry?	_
	th wil	ai D	4400 Franc	onia	Drive				21206	·			US	A	
	tams tams	nei	11. Marital Status		12. Was Decedent 8 Armed Forces?		13.	Was Decede	nt of Hispar y Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Ame Black, White		
22	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelih and Mental Hygiene. If Heelih and Mental Hygiene. The Heelih and T 1s marked other than "natural", or itams 23s or 28s-1 show other traumatic svent, the Medical Examiner must be notified at	þ	1 Never Married 2☐ 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes 2 🜠 N If Yes, Give Year or Dates:	0		1 □ Yes 2	_	pecify:				Black	
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	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Se	rvice Licer	1500	_	22	2. Name and		•			e, Md.		
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	Physician /Medical Examiner		23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	(Due to (or as a	Res consequent S/Se	pira e of):	tory	Arre				vern	Approximate Interval Between Onset and Death	5
,00,00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. which is the redeath. To the Funerel Director: Attenthis certificate has been signed by the attending physician and to the Funerel Director. Attenthis certificate has been signed by the surfact transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Possib Due to (or as a	le P	nel	moi		٠				Н	
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9	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours attended to the thin 24 hours attended to the Funder desire death or the Funder Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic preg Other <i>(spec</i>				230	d. Date of deli Month	very Day Year	
ŗ	that ned b	by Pr	Part II. Other significant co	n ditions c	ontributing to death bu	t not resulting	g in the ur	nderlying cau	use given in	Part I.	23e. Did to	bacco use	contribute to	the cause of death?	
25	quire on sig uld be	ed b	CARLIN	MA	PROSTATE	S/P Su	Myer	4 BL	testicu		1 🗆 ነ	es 2 🛂	No 3□Pro	obably 4 Unknown	
	he faw re e has bee ige 2 sho	Completed	Chue	luciak	y + Rael	lie Kus	thy	0		Removal	autop perfo	sy med/	prior to death?	topsy findings available ompletion of cause of	_
g	an: 1	0	25. Was case referred to m	edical					26.	Place of Deat	1 ☐ Yes h <i>Check on</i> o	2 I No	1 🗆 Yes	2 No	-
>	nysici lis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 Inpatier	nt 2 ER/	Outpatien	t 3 DOA	Other: 4	☐ Nursing Ho	me 5 Resid	lence 6	Other (Spec	ufy)	
5	nding Pt th. : After the tuneral			ending ivestigation	28a. Date of Injur (Month, Day	Year) 28t	o. Time of Injury	280 M	c. Injury at Work?		28d. Describe h	ow injury o	occurred		
SINIS	al or Atte after des I Diracto d in by th	Certification:		ould not be etermined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, str	eet, factory,	office		28f. Location (5 City or Ton		vumber or Ru	ral Route Number,	
	Hospit 24 hours Funere letely fille	edical (29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Ph dicel Exan	ysician: To the best on niner: On the basis of and manner sta	examination.	lge, death and/or inv	n occurred at vestigation, in	the time, dans opinion	ate and place, n, death occurr	and due to the ored at the time, or	ause(s) ar	nd manner as ace, and due	stated, to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of d	ertifier	i dopon	(RESID	ENT) 29c.	License nun			29d. Date s	signed (Month	Day, Year)	
1			30. Name and address of p	erson who	completed cause of de	ath (Item 23a	а) (Туре,	Print)	ta l	5601	Loch Ro	ו מישון	Rlud	Balton, MD 21230	G
	Sta Registr	- 1	31. Date filed (Month, Day,	Year)	Good 32. Registed	r's Signature	de	Spel		0601		0001		MU 2123	1
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DHMH 17 Rev 1/2001

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Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1⊠M 2□F 59 Director 216-44-6033 MAR. 1946 MARÝLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ral, or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 CEDAR DRIVE 21144 UNITED STATES Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16b. Kind of Business/Industry and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EOUIPMENT OPERATOR CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental H int: If item 27 is marked of PALMER GRANVILLE GIBIS LILLIE MAE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN M. GIBIS / WIFE 1810 CEDAR DRIVE, SEVERN, MARYLAND 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition AUG. 22, 1 X Burial 2 Cremation 3 Removal from State njury or permit. Page Department of Important: If any injury or ' 4 □ Donation 5 □ Other (Specify) ELKRIDGE, MARYLAND MEADOWRIDGE MEM. PK. 2005 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME. P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 21. Signature of Fullera Service Litensee Part1. Enter the libe ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the Immediate Cause (Final disease or condition resulting in death) **Physician** nus /Medical Due to (or as a sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuwes Fri jury) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ben signed þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an c rtificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No 1 Yes Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified ay M.D D39505 AUGUST 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUDHISHTRA MARKAN, M.D., 305 HOSPITAL DRIVE, GLEN BURNIE, MARYLAND 21061 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 2 4 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		1	FOR	partment of Health and Me partificate of Death		0. 2	
		*	1 - Stete Registrar 1. Decedent's Name (First, Middle, Last)	2	Reg. No. 2. Date of Death	2005 2 Time of Dealin L	
	Physicia /Medic	in	LAURA GARDNER	<u> </u>	Walst 23	2005 10 30 AM	
	Examin		4a. Facility Name (If not institution, give street and number) CHAPEL HILL No.H.	4b. City, Town, or Location of Death RANDALLSTOWN		County of Death RALTIMORE	
3r .	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	The second secon	3. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign	_
	Director		216 03 9129 1□ M 2 X F 90 Yrs. Usual Residence of Decedent		Dec 2 19	AIY MARYLAND	_
	yland yland	-	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits	
	Ba-fsl	ctor		HUSTOWN	140.00	1 □Yes 2√No	_
	with th	Funeral Director	10e. Street and Number Robosson Roas	10f. Zip Code	log. Cal	tizen of What Country?	
	death	nera		Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.	_
36	be filed within 72 hours after death with the Maryland ntal Hyglene. ed other than "natural", or Items 23s or 28s-1 show event, It s Mariled Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🜠 No If Yes, Give 9 Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: white	
2-00	72 hou natura		(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working		Cind of Business/Industry	
121	within ene. than "	Completed	life.	Homemaker	0	ww Home	
Maryland 21215-0036	be filed tal Hygi d other event, I	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden		
ylaı	2 should be and Mental Is marked of aumatic eve	70	HARJEY R. Dixon	iling Address (Street and Number or Rural I	Pr BAR.		
Mai	コートマ			a 4	Sykesville		
ore,	of H		20a. Method of Disposition 20b. Place of Disposition	position (Name of Dai	ite 20c. Lo	ocation - City or Town, State	
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		4 Donation 5 Other (Specify)	remation, Inc 8/23/	2005 HAI	MPSTEAD, MO	_
Bal	permit. Departn Imports any inje			22. Name and Address of Facility Jav 5028 SYKESVILLE RO	-		1
	*		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each ince.			Approximate Interval Between Onset and Death	
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	Examiner		Sequentially list conditions, b.	·			
	bed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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8760	cate be physicial the bu	dical	d				_
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
O. B	e death	Physician/Me		B Ectopic pregnancy Direction (specify)		Month Day Year	
Δ.	The law requires that the de ate has been signed by the a bage 2 should be detached to		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?	
rds,	equires an sign	ed by			1 ☐ Yes 2	No 3 Probably 4 □Unknown	
Record	e law requ has been je 2 shoult	Completed	HTN		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?)
al		e Cor	25. Was case referred to medical	26. Place of Death	1 Yes 2 No		_
f Vital	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No	Other	e 5 Residence	6 Other (Specify)	
ou of			27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		8d. Describe how inju	ury occurred	
Division	l or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		8f. Location (Street as City or Town, State	and Number or Rural Route Number,	-
Ö	E Sight						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	ath occurred at the time, date and place, are investigation, in my opinion, death occurred	nd due to the cause(s d at the time, date an	s) and manner as stated. In place, and due to the cause(s)	
	To the Within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)	
•				U 375 13	AUJ	Just 23, 2005	
			30. Name and address of person who completed cause of death (Item 23a) (Type	5t. Reisterstown	MD -	71136	
		ate	31. Date filed (Months 1994, Year) 2005 32. Registrar's Signature	parti			
	Regist	ग्वा					_

Maryland 21215-0036

HUMPHRIES,

Box 68760. P.O. Records. Division of Vital

State of Maryland / Department of Health and Mental Hygiene State Amend Item 18 per fh G846 8-24-05 tas Registrar Amend Item 6 per fh G846 Certificate of Death8-31-05 tasReg. No 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 00 DM Humphries August 18 2005 Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Ballimore hospital of Baltimore Dinai If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Director 242-58-4255 NC 08 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Funeral Director Baltimore NA MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a 21223 U.S.A. 1213 Glyndon Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 Tho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specity: Specify: ð 3√2 Widowed 4 □ Divorced Black "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Receptionist 8th grade L. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Wyche Joepond Wyche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 is any injury or other trau 1213 Glyndon Ave, Baltimore, Md Kevin Humphries-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/26/05 Glen Burnie, Md Cedar Hill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4368 Wasash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to home flats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ₺ No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number latchuenden, MD August 18 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Ballimore hospital Sinai MD MATCHUENSEM, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Willie Ed Hubbard UNK 05-05647 05-05647 RPD **Physic** /Med Exami Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any Injury or other traumatic event, Ita Macalcal Examinating Indiad at QDGB. Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	1 - For State Registrar	State of M	aryland / Depa	artment of r rtificate of			ne No2005	27505				
hysicia	-	Decedent's Name (First, Middle, La Willie		Edd	Hub	bard	2. Date of Death Month August	Day Year 20, 2005	2244 P M				
Medic/ Examin		4a. Facility Name (If not institution, given				or Location of Death	nagast .	4c. County of Death					
		University Hospi 5. Social Security Number 6.3		ge (In yrs. last birthday)	Baltimon	re If Under 24 Hrs.	8. Date of Birth	9 Right	nplace (State or Foreign				
uneral rector		216-08-8469	(XM 2□F	36 Yrs.	Months Days		(Month, Day, Y 06 15	ear) Cot	MD				
A	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
T sh	Ď	MD NA		Baltimo	ce				1 🛣 Yes 2 🗌 No				
128a	Director	10e. Street and Number		1	10f. Zip Code		10g	. Citizen of What Co	untry?				
23a o	a D	3411 Lynne Have	en Drive			21244		U.S.A	•				
E LI	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Special)	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
Important: if Itam 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be notified at once.	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1⊡Yes 2∏XNo				Black				
n "natur Aszlical	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of working)	ing 16	b. Kind of Business/l	ndustry				
e a	E o	Elementary/Secondary (0-12)	College (1-4or na	U ₁	nemploy	ed	1,	Unempl	oyed				
vent,	Bec	17. Father's Name (First, Middle, Las	1)			18. Mother's Name	e (First, Middle, Ma	iden Sumame)					
arked atic e	2	Willie E. Hubb	pard Sr.			Carolyn							
ra mar	1 8	19a. Informant's Name/Relationship			_			City or Town, State, Z	(1)				
m 27 her ti		Willie E. Hubl	pard Sr	-Father 3	411 Lyn			Balto, lc. Location - City or 1					
or ot		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	cemetery, cre	matory or other pla	1C0)							
njury .	Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fungral Service Licensee 22. Name and Address of Facility												
any l		Jalo N	1 arch	M	arch F/	H West ash Ave,	Baltim	ore, Md	21215				
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each I	d the death. Do not en ine.	ter the mode of dy	ing, such as cardiac o	or respiratory arrest	t, ·	Approximate Interval Between				
sician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Multiple Gunshot Wounds											
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ısıt	nine	il any, leading to inmediate cause. Enter Underlying Cause (Disease or injury											
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physicien and s the burial-transit	cai		d										
O) (G	ledicai					474							
r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		∃Ectopic pregnanc	ey .		23d. Date of deli-					
To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown		Other (specify)			Month	Day Year				
deta	y Ph	Part II. Other significant conditions	contributing to death I	but not resulting in the u	ınderlying cause gı	iven in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
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te ha	autopsy prior to completion of cau performed? death?								2 □ No				
otor, p	Bec	25. Was case referred to medical examiner?				26. Place of Death	h (Check only one)						
his ce I direc	10	1 ☑ Yes 2 ☐ No	Hospital: 1 Inpati	ient 2 🔀 ER/Outpatie	III JU DUA		me 5 Residen	ce 6 ☐Other (Spec	cify)				
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tor:	cat	2 Accident investigate 3 Suicide 6 Could not	he of zo	os 16.23 njury - At home, farm, st]Yes 2 □No		et was s					
Direction by	Certification;	4 Momicide determine	building, e	tc. (Specify)	iee, iadory, omce		City or Town,	et and Number or Ru State) & W Frankh	Bultmore				
filled		29a. Certifier 1 Certifying F	hysician: To the bes	t of my knowledge, deal	h occurred at the t	time, date and place.							
e Fui	Medical			of examination and/or in									
To th	Me	29b. Signature and titte of certifier			29c. Licen	nse number	290	I. Date signed (Month	n, Day, Year)				
	/	1 Jash 3~	Learl 1	up	0.C.	M.E.	Au	gust 21, 2	2005				
1		30. Name and address of person who				et, Baltim	ore, Mary	land 21201	L				
Sta	ite	31. Date filed (Month, Day, Year)											
Registr	oute and the second sec												

Physician /Medica Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

	1		For State Registrar	State of M	aryland / Depa	artment of He rtificate of D		Re	eg. No2005	27587
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Las Ruth</i>)	F	Iamilton		2. Date of Deat Month	200 ^{Day} 2005	9:05a M
	Examir	451	4a. Facility Name (If not institution, give 1818 N. Colling			4b. City, Town, or L Balti	ocation of Death		4c. County of Death	A
F.	Funeral Director		5. Social Security Number 6. Se 214–26–4485	x 7. A	ge (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7-1-3)		place (State or Foreign ntry) S.C.
	aryland ahow	_	Usual Residence of Decedent 10a. State 10b. County M.d. N.A		10c. City, Town or Lo	ocation imore				10d. Inside City Limits 1 Yes 2 □ No
	se or 28a-f	Funeral Director	10e. Street and Number	on Ave.		10f. Zip Code	1213	1	0g. Citizen of What Cou	
036	d within 72 hours after death with the Maryland Jiene. I then "natural", or items 23e or 28e-f ahow I te Madical Examination by notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of Hisi Was Decedent of Hisi If Yes, specify Cuban, 1 ☐ Yes 2 ☐ Xio	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: BL	
21215-0036	c = 3	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation le <i>completed)</i> College (1-4or	5+) (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion Iring most of worki	ing	16b. Kind of Business/li	,
land 21	be filed trai Hyg od otha avant.	To Be Con	6th grade 17. Father's Name (First, Middle, Last) John	1	Montgomery	Domestic	18. Mother's Name			ople Homes
, Maryland	Ith a	-	19a. Informant's Name/Relationship (7 William Hamilton		19b. Maili	1818 N.	nd Number or Rura Collingto	n Ave.	City or Town, State, Zi Baltimore,	^{Code)} 21213
Baltimore,	0 0	9	20a. Method of Disposition 1 □Xurial 2 □ Cremation 3 □ 1 □ Conation 5 □ Other (Specify			esition (Name of matory or other place) Mem. Pk.)	26 - 05	20c. Location - City or T Randallsto	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	wan		2. Name and Address March F.H			imore, Md. E. North A	
	Pnysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Nov	-Small	0.11	^		est,	Approximate Interval Between Onset and Death YearS
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and coage 2 should be detached for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequence of): s a consequence of): s a consequence of):					
.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Q	uires that the signed by	by	Part II. Other significant conditions of	entributing to death	but not resulting in the u	nderlying cause given	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Vital Records,		Completed						24a. Was a autops perform	y prior to co	opsy findings available ompletion of cause of
of	ding Physician: The h. h. After this certificate h. funeral director, page	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D	ury 28b. Time o	nt 3 DOA Other	4 Nursing Ho	me 5 Heside	e) ance 6 Other (Speci ow injury occurred	fy)
Division	or Atten ifter deat Diractor: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	280. Place of Ir	njury - At home, farm, st atc. (Specify)		es 2 No	28f. Location (St. City or Town	reet and Number or Rur , State)	al Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	29a. Certifying Ph. (Check only one)	vsicien: To the bes iner: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the time vestigation, in my opio	e, date and place, nion, death occurr	and due to the ca	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
	With Com	E	29b. Signature and title of centiler		ONCOLOG-1	7	0 56°	919	9d. Date signed (Month,	Day, Year)
	Str	ate	30. Name and address of person who of the control o	NEGAN	death (Item 23a) (Type, 6569 trar's Signature	NORTH (HARLE	s 5T.	BATTER	B 21204
DH	Regist		AUG 2 4	2005	wo &	forte				
					ORIGIN	AL				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Mai	yland / L	Jepartme <i>Certifica</i>			mental Hy	rgiene Reg. No.2	O E	27600
	F-8-3-16		1. Decedent's Name (First, Middle, La	nst)					2. Dete of De	eath	0-0	3. Time of Death
	Physici		Leron		Ha	VVIJA	24	5 4.	Month	Day	Year	10:50a.m
1	/Medic Examir		4a Fecility Name (W not institution, give	re street and number)				4b. City, Town, or	Location of Deal	19 200 th 4c. County	of Death	10.30a.m
1	Examir	ier	Lorien Frankf					Baltimo	ore		N/	A
	Francis		5. Social Security Number 6. S		'In yrs. last bir	rthday) If Und	ler 1 Year	If Under 24 Hrs		rth		
	Funeral Director			1 □ ¥M 2□ F		Yrs. Month	s Days	Hours Min.	8. Date of Bi (Month, Di	10 13	Country	ce (State or Foreign
	and and		10a. State 10b. County	1	0c. City, Tow	n or Location					10c	d. Inside City Limits
	Mary	ō	MD N/	A	Bal	timore						1 AYes 2 □ No
	the 288	5	10e. Street end Number			10f. Z	Zip Code			10g. Citizen of V	Vhat Country	17
	₹ S		2713 E. Prest	on Street			212	213		US	3 A	
	leath is 2	era	11. Marital Status	12. Wes Decedent Ev	er in U.S.	13. Was Dec		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No	0- 14. Raci	e - American	ı Indian,
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!, or items 23a or 28a-f show important: If item 27 is marked other than "hatter!, or items 23a or 28a-f show important; if item 27 is marked other than an anotal and an anotal and anotal and anotal anotal and anotal an	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖾 ₩idowed 4 ☐ Divorced	Armed Forces? 1XXes 2 □ No If Yes, Give Year or Dates:			ecify Cub 2. No		to Rican, etc.)	Specify	k, White, etc Bla	
ŏ	2 ho	8	15. Decedent's E	ducation	16a.	Decedent's Us	sual Occup	pation		16b. Kind of Bu		
75	Z ulu	pie	(Specify only highest grant (Specify only highest grant (9-12)	ade completed) College (1-4or 5+)		(Give kind of v life. DO NOT	vork done use retire	during most of wo d)	rking			
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P	ent,	Be C	17. Fether's Neme (First, Middle, Last)		DULITO		18. Mother's Na	me (First, Middle	, Maiden Surnam		
Maryland	Mental Mental arked o	To B	Ryan	Harrison				Arı	meicy			
E S	should and Men merke umatic	-	19a. Informant's Name/Relationship	Type, Print)	19b	. Mailing Addre	ss (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip C	ode)
	and 2 salth a n 27 is		Joyce Watkins	daughter		7406 Vi	rgini	a Avenu	e North	ingham,	MD	21236
ā,	Hea Hea tem		20a. Method of Disposition		.L	f Disposition (N	_		Date	20c. Location -		n, Slate
Baltimore,	permit. Pages Department of H important: If ite any injury or of once.		1 Donation 5 ☐ Other (Special	y)	Crow	nsvШe	VA	Cem.	8/26/05	Crown	sville	MD
Bal	Departimbor		21. Signature of Funeral Service Lice	w wa	ne_			ess of Facility North A		FUNERA Baltimor		
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7	Physician		Investigate Cours (Circle								1	Tiset and Death
7	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Pn.	env	non	ra				l l	
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P.0	that the de led by the si detached i	E	0/1		٠ م. ا				10	Yes 2□ No	3 - Frobal	bly 4 □ Unknown
	Se De	Completed by Physician/N	disease	JA MUCIC	ve f.	olmo	nun	9				
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>	Physician: r this certific and director,	2	examiner? 1 ☐ Yes 2 ☐ N o	Hospital: 1 ☐ Inpatient	2□ ER/Ou	utpatient 3 🗆 [DOA Ott	ner: 4. Hursing I	lome 5 ☐ Resi	idence 6 □Othe	er (Specify)	
10	er thi		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. 7	Time of njury	28c. Inju	ry at	28d. Describe	how injury occurr	ed	
<u>Ö</u>	Attending or death. • ctor: After by the fune	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio			M		Yes 2 □ No				
Division	Atte octo by th	2	3 ☐ Suicide 6 ☐ Could not be determined		- At home, fa	ırm, street, facto	ory, office			Street and Number	ar or Rural P	loute Number,
Ö	s afte	Certification:	4 🗆 Homade	building, etc. (Specily)				Ony or 10	wii, olatoj		
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	othi othi ompl	M	29b. Signature end title of certifier			2	9c. Licens	se number		29d. Date signed	(Month, Da	iy, Year)
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	Sta Registr		AUG 2 4	2005	w D.	Acres	المستا					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST **Physician** 18 9:36 Am HOWELL 20 05 SARA ELIZABETH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GWYNN OAK 3112 JEFFREY ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Pear) | 1 | 0 1 / 0 4 / 1 9 1 6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F 219-10-5979 89 MÄRYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No N/A BALTIMORE CITY MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 2815 MOHAWK AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: BLACK Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Complet BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOL SYS. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: If I tem 27 is marked other the eny injury or other treumetic event, If a 9008. EDUCATOR/TEACHER 12TH 6 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OLIVER PAIGE ROSETTA FOX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SARA SMALLEY / DAUGHTER 3112 JEFFREY RD, BALTIMORE CO., MD 21244 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MD cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/23/05 CEDAR HILL CEM. BROOKLYN, A.A. CO., 21. Signature 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 aleral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, fer the disease, or complications that caused the death, eart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate ause (Final diseas Condition resulting in death) Metaslatic Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician Box 68760 an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Physici 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknow Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel I 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 2 119/2005 9. Kause D25112 30. Name and address of person wito completed cause of death (Item 23a) (Type, Print)
TAHOORA KAWAJA 20, crossroads Drive Suite 101 MDZIIIT 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 2 4 2005 Registrar

HOUGH Baltimore, Maryland 21215-0036 RICHARD

Physicia /Medica Examine

Physi /Med Exam

Funera Directo

permit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 _ State	State of Maryland		ertificate of l		Meritarriyg	lietie		
Registrar	.41	06	erinicale of t	Jean	2. Date of Deat	eg. No.2	27695	
Decedent's Name (First, Middle, Las	•		-		Month	Day Year		
	d Thomas Hou	ıgh,			August	15 2005		
4a. Facility Name (If not institution, give		25	4b. City, Town, or			4c. County of Dea	ath	
SINAI HOSPITAL 5. Social Security Number 6. Se			BALTIME:	If Under 24 Hrs		l N/A	rthplace (State or Foreig	
11	LZ.	52 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Country)	
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10a. State 10b. County	10c. City	, Town or L	Location				10d. Inside City Limit	
Maryland Carrol	1		Woo	dbine			1 □ Yes 2 XN	
10e. Street and Number			10f. Zip Code	COLIN	1	0g. Citizen of What C	Country?	
15025 Martlock H	Road		21797			USA		
11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13	I. Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Race - Am		
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3 ☐ Widowed 4 X Divorced	Year or Dates: 1961-	63	1 162 5 VIA	Specify.		Specify:	White	
15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dec	edent's Usual Occupa	ation during most of wo	rkina	16b. Kind of Busines	s/Industry	
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12			Oriver				CCIOII	
17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, I	Maiden Sumame)				
Thomas B. Houg	h			Ja	ne Selhor	st		
19a. Informant's Name/Relationship (7	Type, Print)	19b. Mai	lling Address (Street a	and Number or R	ural Route Number	, City or Town, State,	Zip Code)	
William L. Hough	h/Son					, MD 2106)	
20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	20b. PI	ace of Disp emetery, cr	position (Name of ematory or other plac	θ)	Date	20c. Location - City o	r Town, State	
4 □ Donation 5 □ Other (Specify		ro Cr	rematory,	Inc. 8/1	9/05	Baltimore	a. MD	
21. Signature of Funeral Service Licen-	See 0 1		22 Name and Address	s of Facility				
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State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2005

2. Registrar's Signature

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			Registrar Decedent's Name (First, Middle		1 0	ertificate of	Dealli	2 Date of De	Reg. No.2	05 -	3-Time Death	
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	/Medic Examir		Paul A. Ho 4a. Facility Name (If not institution	give street and number,)	4b. City, Town, o	r Location of Death		4c. County		J.10 P	
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7	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthd	lf Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign	
7	Director		214-91-8649	1₩ 2□F	15 Yrs	Months Days	Hours Min.	Sept16		MD.	rmry)	
9	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		1	ESTAIN		10d Inside City Limits	
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980	urs after d	by Funeral Director	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces	No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)		k, White, ∕Blac	etc.	
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/lai	Venta	10	John T. Linth	nicum								
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ore	ges 1 t of H if ite		20a. Method of Disposition 1 Darial 2 Coremation	thod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To								
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Baltimore,	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business A (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi Helicans 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 2										.213	
-11			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each I	d the death. Do not line.	enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
2	Physician	2.33	Immediate Cause (Final disease or condition	Arterios	sclerotic	cardiovaso	cular dise	ease			Onset and Death	
	/Medical Examiner		resulting in death)	W1 100	s a consequence of):							
	Laminer		Sequentially list conditions,	b								
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P.O. Box	requires that the death certificate be executed een signed by the ettending physicien and nould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Dat Mo	e of delive	ery Day Year	
	that the	y P	Part II. Dther significant conditio	ns contributing to death t	out not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?	
rds	quires n sign uld be	Completed by	HIV seropositiv	e				10	Yes 2 □ No	3 🗆 Prob	pably 4 □Unknown	
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	_		1/8 lon	KellI		0.0	C.M.E.		August	16,	2005	
_	N		30. Na d address of person v	who completed cause of	death (Item 23a) (Typ	e, Print)			9	,		
	V	3	U. LAREN	LOKE, an	111	Penn Stre	eet. Balt	imore	Marvland	L_212	01.	
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	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last birthday, 89 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Year 0 13	Cou	place (State or Foreign ntry) SC
	D ≥	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	shov	- 1		Roseda	Doi	sterstown			Yes 2 □ No
	the N	Director	MD NA 10e. Street and Number	Roseda	10f. Zip Code		10g. C	itizen of What Cou	intry?
	with					1136		II C A	
	eath	era	12020 Reisterstor	Vn Road Vas Decedent Ever in U.S. 13.		Hispanic Origin? (Specif van, Mexican, Puerto Ric	y Yes or No-	U.S.A 14. Race - Amer	ican Indian,
36	d 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. 77 is marked other than "netural", or items 23e or 28e-1 show traumatic event. I'm Modical Examinar must be indiffed at traumatic.	by Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 No f Yes, Give Year or Dates:	If Yes, specify Cub 1 ☐ Yes 2 X No		can, etc.)	Black, White	lack
21215-0036	2 hou	fed	15. Decedent's Education		edent's Usual Occu	pation during most of working	16b.	Kind of Business/l	ndustry
75	within 72 ene. than "n	Completed	(Specify only highest grade co.	College (1-4or 5+)	DO NOT use retire	ed)			
21	d with giene ar tha	E O			ome Mak	1		House	
פ	e filed at Hygie other vent,	ВеС	17. Father's Name (First, Middle, Last)			18. Mother's Name (F		n Sumame)	
<u> a</u>	should be 1 nd Mental I marked o	To	Jessie B. Anders			Annie Wi			
Maryland	2 shoul and Ma is marl aumati		19a. Informant's Name/Relationship (Type,			t and Number or Rural F			
	C = '' =		James Kidd JrS			ora Ave,			21237
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other QDC8.		20a. Method of Disposition 2 □ Cremation 3 □ Remo		ematory or other pla	ice)		Location - City or 1	
Ĕ	Pag ment ant: i		4 □Donation 5 □ Other (Specify)	Garriso		t Vet. 8/	26/05 0	wings M	ills, Md
at	pparti		21. Signature of Funeral Service Licensee	J/ L. M	2. Name and Addr	ess of Facility H West			
<u> </u>	905 20		My D.	Rete 4	300 Wab	ash Ave,		re, Md	21215 Approximate
			23a. Part I. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complex states and the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex to the complex states are complex states are complex to the complex states are complex states are complex states are complex states.	ons that caused the death. Do not en ause on each line.	nter the mode of dy	ing, such as cardiac or r	respiratory arrest,		Interval Between Onset and Death
	Physician	0 .	Immediate Cause (Final disease or condition	RESPIRATORY FA	ILURE				
	/Medical		resulting in death)	Due to (or as a consequence of):					
	Examiner	. 1	Sequentially list conditions.	PNEUMONIA					
	p ii	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
	and and trans	Examin	that initiated events c.	Due to (or as a consequence of):					
30,	oe ex	Ē		545 to (0. 45 4 55.150455.100 5.).					
68760,	icate be executed physician and s the burial-transit	edical	d						40000
_	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23c	If yes, outcome of pregnancy				23d. Date of deli	verv
Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	in the past 12 months?	1 Live birth 2 Fetal death 3	☐ Ectopic pregnan	cy		Month	Day Year
	the de	ysic	1 ☐ Yes 2 12 No 9 ☐ Unknown	9 Unknown					
P.0	res that the de signed by the a be detached f	H.	Part II. Other significant conditions contrib	outing to death but not resulting in the	underlying cause g	iven in Part I.	23e. Did tobacci	o use contribute to	the cause of death?
ds,	sign d be	d by					1 🗆 Yes	2 12 No 3 □ Pr	obably 4 🗀Unknown
Records,	w requir been si should	Completed					24a. Was an	24b. Were au	topsy findings available
3e	The fav	d E					autopsy performed	death?	completion of cause of
a		e Co	25. Was case referred to medical			26. Place of Death ((Check only one)	Vo 1 ☐ Yes	242 140
Vital	Phyalcian: r this certific ral director,	00	examiner?	pital: 1 Inpatient 2 ER/Outpati	ent 3 DOA	thor	e 5 Residence	6 ☐Other (Spec	cify)
of	F F Ja	To :		28a. Date of Injury 28b. Time	of 28c. Inj		3d. Oescribe how in		,,
Division	Attending r death. ector: After oy the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1	ork? □Yes 2□No			
:2	Attendi death. ctor: A	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,	street, factory, office	e 28	Bf. Location (Street City or Town, Str		ıral Route Number,
Ö	after Dire	erti	4 Homicide	building, etc. (Specify)			ony or rown, on	ato,	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f	Medical C	29a. Certifier (Check only one)	ian: To the best of my knowledge, de : On the basis of examination and/or and manner stated.	ath occurred at the investigation, in my	time, date and place, ar opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 7 To the comple	Me	296. Signature and title of certifier	O W	29c. Lice	nse number	29d. l	Date signed (Mont	h. Day, Year)
	⊢≯⊢ŏ	/	FRICE-1	_wthican =		1826	8	-18-0	5
	1/1		30. Name and address of person who comp	pleted cause of death (Item 23a) (Tvn		at had been het			
	1					HE TOLICON	MORYLA	ND SIDA	4
	S	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		va rewach		1 1/12 L. L. L. L. L. L.	,
	Regis	rar	AUG 2 4 200	5 Alphan B.	Goods				
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DHMH 17 Rev 1/2001

ORIGINAL

				1 - For State Registrar	State of	Marylan	•	artment of F	Health and	Mental Hy	giene	05	27601
	S. S.	Physici	an	1. Decedent's Name (First, Middle, Las	ilia Lou	iso Vi		unouto or		2. Date of D	eath Day	Year	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give	street and num		3.L	4b. City, Town, o	or Location of Deat	AUGU	ST 20, 2	005 of Death] 3:30a [™]
	v 5			Gilchrist Center 5. Social Security Number 6. S		. Age (In yrs.	last hirthday		WSON If Under 24 Hrs	8. Date of B	rth		cimore
	差(Funeral Director		218-12-4273	ом 20 г	. Age (111 yrs.	88 Yrs.	Months Days		. (Month, D	ay, Year) 8, 1917	Cou	cyland
		ehow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
		ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow or other treumatic event, Ita Madical Examinat must be notified at	Director	Maryland Harfor	rd		Ja	arrettsvj 10f. Zip Code	lle		10g. Citizen of	What Cour	1 ☐ Yes 2 No
		3a or		2425 Linda Lar	ne				.084		US		ny :
		ier death w Iteme 23a ner must i	Funerai	11. Marital Status	12. Was Deced	es?	.S. 13.		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)			can Indian, etc.
	980	72 hours afte "natural", or II	þ	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 □ Yes 2 💢 No			Specif	/: V	White
	Maryland 21215-0036	n 72 ho "natur edicel	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occur kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of B	usiness/In	dustry
	212	od withi giene. er then	Comp	Elementary/Secondary (0-12)	College (1-	4or 5+)	Homen				Domes	tic	
<	and	the filed intal Hygis ed other covent, I	Be	17. Father's Name (First, Middle, Last, Milton Vincent							a, Maiden Suman 1a Blosl	ne)	
an	aryl	should and Men s marke umatic	스	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or R			State, Zip	Code)
30		l and 2 lealth a im 27 is		Frederick N. Kief	:/husband		2425	Linda La	ne Jarre	ttsville	20c. Location	084	Ctate
3	altimore,	Pages ent of h nt: If ite ry or of		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from S	tate	emetery, crer	natory or other pla	Inc . $8/2$				ce, MD
	Balti	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other freumatic event, II a Magnee.		21. Signatu of Funda Singe Lice	mald		22	Name and Addr L'EMALION	ess of Facility Society	of Mary	yland, I	nc.	
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	DONALQ ptications that ca one cause on ea	used the deat ch line.			rick Roa			D_212	Approximate Interval Between
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	g Cance							Mon 745
\-		Examiner		Sequentially list conditions,	b	ras a conseq	uence ot):						
20/02	14	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ras a conseq	uence of):						
120	,0	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last	c Due to (o	ras a conseq	uence of):						
00	68760,	th the	edical	•	d								
	Вох	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	death 3	Ectopic pregnanc	:y			te of delive	ery Day Year
	0	that the dea ed by the a detached fo	nysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□ Unknov	nt at time of d	eath 5	Other (specify)					Day Toal
ecilia	of Vital Records, P.O.	ires that signed t d be deta	by P	Part II. Other significant conditions of	_						tobacco use cont √es 2 □ No		ne cause of death?
5	corc	w requires been sign should be	leted	Coronary Artery	Uiscase	wage	stive 6	reary ful	10/6	24a. Wa:			nably 4 Unknown
0	l Re	The lay ate has page 2	Somp		-					auto	ormea?	prior to co death? 1 🔲 Yes	psy findings available impletion of cause of
et t	Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			10		ath Check only			• /
1		ng Phys iter this ineral di	on: To	1 ☐ Yes 2 ☐ M6 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 □ In 28a. Date of (Month		28b. Time of Injury	28c. Inju Wo			idence 6 Poth how injury occur		v) Itespice
7	Division	after Attendi after death. Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At h	ome, farm, str	eet, factory, office	Yes 2 No		(Street and Numb	er or Rura	al Route Number,
	ă	Ital or urs after ral Dire		4 nomicide							own, State)		
		To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the base niner: On the base and manne	sis of examina	wledge, death ition and/or in	h occurred at the to vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) and ma , date and place,	anner as s and due to	tated. o the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen			29d. Date signe		•
		12		30. Name and address of person who	2 Mg		n 23a) (Tvoe		61199		Aug. 20	, 100) s
	-	1,		Jason Black 66	ol Nort	th Cha	rks Si	Tous:	on MO	2120	7		
		Sta Registr		31. Date filed (Month, Day, Year) AllG 9 A 20	100	gistrar's Signa	ture do	edi					

8/20/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar	,	Certificate of Death Reg. No. 21695					2/695		
	-		1. Decedent's Name (First, Middle, La	st)			2. Date Monti	of Death		3. Time of Death		
	Physicia /Medic		Helen M. Koza	k			Augu	st 2	$\overset{\text{pay}}{0}$, $2\overset{\text{year}}{0}$ 5	20:35 M		
}	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or L	ocation of Death	- 4	4c. County of Death			
			Upper Chesapea			Belair		15:	Harford			
B	Funeral Director		213-13-7800	ex 7. Age (#	n yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days		5/2I	ar) Coun	lace (State or Foreign yland		
	and w	}	Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Town or Lo	cation			110	0d. Inside City Limits		
	Aaryti Feho	ō			Bela					1 ☐ Yes 2 🛣 No		
	h the Maryland r 28e-f ehow positied et	Director	Md Harfo 10e. Street and Number	r u	рета	10f. Zip Code		10g. (Citizen of What Coun	try?		
	death with the Maryland ms 23a or 28e-f ehow frivest be notified at		1600 Redfield	Road		2101	5		USA			
	ter death	Funerai	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. V		panic Origin? (Specify Yes , Mexican, Puerto Rican, etc	or No-	14. Race - America			
920	72 hours after natural', or Ite	þ	1 ★ Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	Yes 2/28 No	Specify:	<i>i.</i>)	Specify:	hite		
15-0	_ ×	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)	(Give	lent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of working	16b.	Kind of Business/Ind			
12	filed within I Hygiene. other than "rent, It e Med	mc.	Elementary/Secondary (0-12)	College (1-4or 5+)		Secretar	. 77	V	eaton Ói	1		
0	be filed stat Hygi od other event, I	a)	17. Father's Name (First, Middle, Last				8. Mother's Name (First, M			<u></u>		
a	Mental Merked o	To B	Joseph Kozak				Mary Swi	eda				
Maryland 21215-0036	es 1 and 2 should be of Health and Mental if item 27 le marked or rother treumatic eve		19a. Informant's Name/Relationship (Mrs. Susan Cro				y or Town, State, Zip aryland					
ē,	Heal Heal tem		20a. Method of Disposition		20b. Place of Dispos	sition (Name of	Date		Location - City or To			
Baltimore,	permit. Pages. Department of H Important: If ite any injury or of		1 ≤ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Special		St. Sta	natory`or other place) n i s l a u s	8/24/05	Ba	ltimore,	Md.		
alti	permit. I Departm Importai any injui		21. Signature of Funeral Service				kfi Funeral			114.		
ä	Depar Impo		Melle		1201 Dundalk Ave. Baltimore, Md. 21222							
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Acut	Approximate Interval Between Onset and Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death with m 24 ho							
4	Examiner		Sequentially list conditions	b								
	p ti	iner	Sequentially list conditions, if any, reading to transdate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	onsequence off:							
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):							
68760,	certificate be executed ding physician and ise as the burial-transit	aiE			onio quon o o o o o o o o o o o o o o o o o o							
587	ficate phys s the	ledicai		_ d								
.0. Box	The law requires that the death certifule has been signed by the attending agge 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ Mo 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year		
s, p	s that ned b	by Pi	Part II. Other significant conditions	contributing to death but n	ot resulting in the ur	nderlying cause given	in Part I. 23e.	Did tobacc	o use contribute to th	e cause of death?		
rds	n require been sig should b	ed b	Dement	Ĭ.C				1 🗌 Yes	2 → No 3 □ Proba	ably 4 □Unknown		
Record	aw re	Completed	,					Was an autopsy	24b. Were autor	osy findings available inpletion of cause of		
	The lavate has	E O					10,	performed?	death?	20 No		
Viital	iclen: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death (Check					
o t	Physic this ce al dire	ပ္	1 ☐ Yes 2 ☐ No		2 ER/Outpatien		4 Nuising Home 5			9		
	ng f fter iner	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Work?		cribe how in	ijury occurred			
Sic	uttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	e 290 Glaco of Injuny	- At home form str		es 2 No	tion (Street	and Number or Rural	I Pouto Number		
Division	rs after el Direc ed in by	Certification:	4 Homicide determined	building, etc. (Specify)	set, factory, office	City	or Town, Sta	ate)	noute Number,		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medicai			amination and/or inv		, date and place, and due to nion, death occurred at the					
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	1000		29c. License	number	29d. [Date signed (Month, L	Day, Year)		
	1		1 Clam	N'1114	- P	1/1	9583	HI	19USI 2	0,2005		
	6		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	Law Stre	et 10	Kberde	en		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	trar's Signature							
Е	Registr	ar	AUG 2 4 2005	Marin ,	1. Apart	w .						

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			1 - For State Registrar	State of I	Marylan	-	artment of H		d Mental Hy	giene Reg. No. 😝 🕜			
	Physici		1. Decedent's Name (First, Middle, L Michael J. Kopp	•					2. Date of De Month	ath Day	Year 5	3. Zime/of	13°96
	/Medic Examir		4a. Facility Name (If not institution, g Millenium Marle	ive street and numbe	ər)		4b. City, Town, or			4c. County	of Death		.AM
I	Funeral Director		217-03-1339	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da Mar 3,	th ly, Year)		place (State o	or Foreign
	death with the Maryland ms 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne An	runde1	10c. City	y, Town or Lo	cation Burnie				1	0d. Inside Ci	
	th with the 23a or 28	al Director	10e. Street and Number 218 D. Street S	SW			10f. Zip Code	210	61	10g. Citizen of V	What Cour	itry?	
920		by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☆ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin n, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		e - Ameno ck, White, "Whit	etc.	
1213-0038	within 72 hours after ene. than "natural", or ite	Completed	15. Decedent's (Specify only highest g	College (1-4c	or 5+)	(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	f working	16b. Kind of Bu		,	
/lang z	should be filed of Mental Hygis marked other matic event, I	To Be Co	17. Father's Name (First, Middle, Last Jerome Charles			carpe	nter		Name (First, Middle,			ements	3
, mar,	nd 2 s lith ar 27 is r trau		19a. Informant's Name/Relationship Michael Kopple			19b. Mailir			or Rural Route Numbe SW Glen B			Code) 1061	
altimore	Page nent o ant: If arry or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			lace of Dispo emetery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location -	City or To	wn, State	
Dall	permit. Departr Imports any inji		21. Signature of Funeral Service Lid	Wade, Di	vector	St	ritimore,	omy Boa MD 21	ard 655 W. 1201		ore S		
	requires that the death certificate be executed Example of the attending physician and the detached for use as the burial-transit to the confidure of the conf	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Dua to (or c.	as a consequal as a consequal	uence of):	AL I	NFP HYP		DN NS10	MI	Approximation Interval Bath Onset and V	ween
.O. BOX 0	w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	Ideath 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	te of delive		Year
ecords, P	law 2 si	ompleted by PI	Part II. Other significant conditions PAROXY SMA SENILE	contributing to death LATRI DEMI	AL ENT	LIB LA	RILLA	on in Part I.	1 24a. Was	SV	3 Proba		Jnknown available
VICAI N		Be Con	25. Was case referred to medical					26. Place of		2 No 1	death?	2 🗆 No	
	nding Physician: sth. r: After this certific e funeral director,	၉	examiner? 1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending investigati		- 1	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 La vursir	ng Home 5 Resid	dence 6 Other		9	
DIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	3 Suicide 6 Could not determine	d 28e. Place of building,	etc. (Specify	<i>(</i>)	eet, factory, office		City or Tox				ber,
	he Hosp in 24 hou he Funel pletely fil	edical	29a. Certifier 1 ☐ Certifying F (Check only 2 ☐ Medical Ext	Physician: To the be aminer: On the basis and manner	of examinat	wledge, death tion and/or inv	n occurred at the tim vestigation, in my op	ne, date and p pinion, death o	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s	.)
	To t To t	ž	29b. Signatural and title of dentition	Lingh	- ~	10	29a License	Limber (60	29d. Date signed	21	2 0 0	2
			30 Name and Jodress of person who are silved in the same and some silved in the same and same are same and same are same and same are same and same are same and same are same	o RE	strar's Signa	1930) (Typo) ARY 1	AND	2 12	25	UTIE	410	HM	+7
	Sta Registi		SILD O 4 200	5 Agual .	, D	Cont							

			For State	State of Maryla	•	artment of H	Health and		200	·
		_	Registrar		Ce	rtificate of	Death		ag. No. ZUU	27697
	Physici	an	Decedent's Name (First, Middle, La.	•				2. Date of Dea Month	Day Year	3. Time of Death
	/Media			n Charles Lo	ckwoo	d		August	21, 2005	1:20 P ^M
1	Examir	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Dea	th	4c. County of De	ath
			Laurel Regional			Laur			Prince	Georges
	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs Hours Min		(Year) 9. B	irthplace (State or Foreign Country)
	Director		212-14-3092	A 23.	93 Yrs.			MAY 5,	1912 M	laryland
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	Aaryl sho	5	Marenal and Design	C	•	-	-			1 No 2 No
	286-1	ect	Maryland Prince 10e. Street and Number	Georges		Laus 10f. Zip Code	reı	1.	Og. Citizen of What C	1.
	with	급			_					Journay?
	s 23	eral	9010 Briarcroft	Lane, Apt. 30.	15 12		1708	Specify Vac or No-	USA 14. Race - Arr	agrican Indian
	item item	ä	11. Marital Status	Armed Forces?		Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, Wh	
36	rs aff	by Funeral Director	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1□ Yes 2 No	Specify:		Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-1 show te Modical Ext. vit wit wat be trutified at	ed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	
15	in 72	Completed	(Specify only highest gra	nde completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking		a maddily
712	with iene.	l wo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pr	esser			Dry Clea	ning
	filed Hyg other		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,		
lan	ld be ental ked ic ev	To Be	Henry Lockwood				Ten	a Forman		
Maryland	12 should be filed within 'h and Mental Hygiene. 7 is marked other than "traumatic event, tre M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	<u> </u>		r, City or Town, State,	Zip Code)
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28e-1 show any injury or other traumatic event, the Maclical Extending to use to confine at another.		Corrine Lockwood	/Wife	901	0 Briarc	roft Lan	e, Apt. 3	303 Laurel	, MD 20708
ē,	f Hes f Hes item othe		20a. Method of Disposition	20b.		osition (Name of matory or other pla			20c. Location - City of	·
Baltimore,	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 【 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	JRemoval Irom State		ematory,	,	2/1/05	Baltimore	o MD
Ē	artmoortar ortar injur		21. Signature of Funeral Service Licer		2	2. Name and Addre	ess of Facility	24/05	Dartinore	e, MD
Ba	permit. Departr Imports any inj		Edward !		C	2. Name and Addre	Society	of MD, I	nc. re, MD 212	100
	4-51	\vdash	23a. Part1. Enter the disease, or com	orchik plications that caused the dea	th. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arr	est, MD Z1Z	Approximate
			shock, or heart failure. List only Immediate Cause (Final							Intervat Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Cardiac		st				
	Examiner			Due to (or as a conse		V				10.5
b.	th.	e F	Sequentially list conditions, if any, leading to immediate	b. NIGHT Due to (or as a conse		Knee Am	pulalio)N		10 Days
P	nsit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. Gangren	A					3-6 mos.
	e be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse						5 0 mos.
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	ical	(ASVD						3-5 yrs.
89	ficate p phys is the	B		0.						
ŏ	death certifica attending pt for use as th	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of de	elivery
ă	death atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnanc; □ Other (s <i>pecify)</i> _	y 		Month	Day Year
0	that the de ned by the a detached	Physician/M	9 □ Unknown	9□ Unknown						
σ.	es that igned b	by P	Part II. Dther significant conditions of	contributing to death but not re	sulting in the u	ınderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	quires n sign uld be	d b	Dementia, Wour	d Infection	·			1 🗆 Y	es 2 No 3 F	robably 4 Dunknown
00	w requ	Completed						24a. Was a	n 24b. Were a	utopsy findings available
Re	he lav e has ige 2	mc						autops	med/ death?	completion of cause of
a	ician: Th certificate rector, pag	e C	25. Was case referred to medical			-	OR Bloom of Do	1 ☐ Yes :		s 2 No
Vital	uing Physician: The	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2] ER/Outpatie	nt 3 DOA Ott			ence 6 Other (Sp.	acity)
of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	вспу)
Division	iding F th. After funera	Certification:	1 Natural 5 Pending 2 Accident investigation		Injury		rk? Yes 2. □No			
/isi	Attendir death.	flea	3 ☐ Suicide 6 ☐ Could not b	289. Place of Injury - At r	nome, farm, st	reet, factory, office		28f. Location (Si	reet and Number or F	Rural Route Number,
Ö	after after Direct din by	ert	4 Homicide	building, etc. (Spec	ity)			City or Town	n, State)	
	spita hours nera / filler		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my kn	owledge, deat	h occurred at the tie	me, date and place	e, and due to the c	ause(s) and manner a	is stated.
	Ma Ho	Medical	(Check only 2 Madical Examone)	niner: On the basis of examin and manner stated.	ation and/or in	ivestigation, in my o	ppinion, death occi	urred at the time, d	ate and place, and du	e to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Me	29b. Signature and title of certifier	/	1	29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)
			1 3 rune	norton	AS.0	но(059310		August 22	2. 2005
	^		30. Name and address of person who	completed cause of death (Ite	723a) (Type.					-, 2005
	3		Bruce Neckrit				ck Drive	e. #223	. Laurel	MD 20707
	Sta		31. Date filed (Month, Day, Year)	327Registrar's Sign		arto B				,
	Registr	ror.	AUG 9 1 20	B5 1800 - 1	600	1				

			1 - For State Registrar	C. d. Harris		f Maryla	nd / Depa <i>Cei</i>	artmen rtificat			and M		Reg. No.	2001	5,27	698
М	Physici	an	1. Decedent's Name (First, M		•	LED.	D64/					2. Date of De Month	Day			of Death
7	/Medic Examin		4a. Facility Name (If not instit				0070	4b. City,	Town, or	Location o	f Death	Aubus I		1, 2005 County of De		
	LAGIIII	Ÿ	Johns Hopki	W 3 13	AULIEW	MEVECAL	CENTER	BA	LTEA	1.RE	CI	TY				
	Funeral Director		5. Social Security Number 213–36–7163		x DM 2□F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir 7/5/19	th iv. Year) 39		rthplece (State Country) ryland	or Foreign
	land ow		Usual Residence of Deceder 10a. State 10b. Co			10c. C	City, Town or Lo	cation							10d. Inside	City Limits
	Mary B-1 sh	ţ	MD	N/A	1]	Baltimo	re							₩ ∑ Ye	s 2 🗆 No
	ith the	Olre	10e. Street and Number			•		10f. Zip					10g. Cit	izen of Whet (Country?	
	a 23a	ra	3023 Brendan	Aver			110		2121					U.S.		
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than *natural', or itema 23e or 28e-f show apprintly or other traumatic event, the Medical Examinar rotal be notified at angles.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 3 Widowed 4 Divo		Armed For 1 Yes If Yes, Give Year or D	200 No ve		Yes, spec		n, Mexican Specify:	nr (Spe , Puerto	cify Yes or No Rican, etc.))-	14. Race - An Black, Wh Specify: W	ite, etc.	
200	72 hou	ted	15. Dece (Specify only hi	dent's Edi			16a. Dece	dent's Usua	I Occupa	ation during most	of worki	na	16b. K	ind of Busines	s/Industry	
2	Atthin ne.	mple	Elementary/Secondary (0-		College (1-4or 5+)	life.	DO NOT us	e retired)		·g	Pop	awh a aw	1 Compa	
72	'iled w Hygier ther th	Col	17. Father's Name (First, Mid	dle (ast)			Engi	ne Ko	om H	lelper		(First, Middle			1 Compa	ny
Baltimore, Maryland 21215-0036	d be f	To Be	Irving Leddo									Stack		Sumamo		
ary	shoul ind Me i mari umati	ř	19a. Informant's Name/Relat	ionship (T	ype, Print)	_	19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Numb	er, City o	r Town, State,	Zip Code)	
Σ	and 2		Kathleen Led	don/W	life						ue B	altimo:	re,	Mary1a	nd 2121	3
ore	of He if iten	. "	20a. Method of Disposition 1 Burial 2 □ Cremat	ion 3 □I	Removal from		Place of Dispo cemetery, crer					ate	20c. Lo	ocation - City o	r Town, State	
Ë	t. Pag tment rtent: njury o		'4 □Donation 5 □ Othe	r (Specify,	1	Mo	oreland				8/25				Maryl	
Ba	Depa Impo any is		21. Signature of Funeral Ser	15			H	6415	Bela		ad B	altimo:	re,		al Hom nd 2120	6
	Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only o	a. CA	RI) TA (or as a conse				THM					Approximal Interval Be Onset and 36 He	etween I Death
8760,	sate be executed by sicien and the burial-transit	Ilcal Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	~	c.	(or as a conse										
P.O. Box 6	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown			ointh 2 Fet nant at time of	tal death 3	Ectopic pr Other (sp					2	23d. Date of de Month	elivery Day	Year
	uires that signed by Id be deta	þ	Part II. Other significant con	ditions co	ntributing to de	eath but not re	sulting in the u	nderlying ca	ause give	en in Part I.			obacco u Yes 2		to the cause of	
Division of Vital Records,	The law requirate has been single 2 should	Completed										24a. Was autop perfo 1 🗆 Yes	osy ormed?	prior to death?	utopsy findings completion of s 2 \(\text{No} \)	s available cause of
/ita	ertifica ector,	Be (25. Was case referred to me examiner?	100							of Death	(Check only o				
on of \	To the Hospitel or Attending Physicien: The within 24 Hours after death. To the Funeral Director; After this certificate his completely filled in by the funeral director, page	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe	-		inpatient 2 [of Injury th, Day Year)	28b. Time of Injury		8c. Injury Work	at	2	ne 5 Resid			ecify)	
Divisi	el or Attending s after death. Il Director: After d in by the fune	Certification;	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place buildi	of Injury - At I	home, farm, str hify)			Avenue a		28f. Location (3 City or Tox			iural Route Nui	nber,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifier (Check only one)	ifying Phy ical Exam	iner: On the b	best of my kn asis of examin ner stated.	nowledge, death nation and/or inv	occurred a	at the tim in my op	ie, date and pinion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) date and	and manner a I place, and du	s stated. e to the cause(s)
	Withi To 11 comp	ž	29b. Signature and title of ce	rtifier				29c	. License	number			29d. Dat	e signed (Mor	th, Day, Year)	
,	1		Christophe		ngdm	O MEUSC	AL DOCTOR	U F	ES.	-000	0	A	4464	UST 21	2005 ALTEMO	
1	0		30. Name and address of per													
	Sta Registr	te	31. Date filed (Month, Day,	16 ECM	2005 32. R	IE JOHN Legistrar's Sign	13 Hopksi	AS MOS	A LYC	, 600 /	VORT	1 WOLF	≤ srn	EET MA	My (A~1)	21287

			For State Registrar	State of Mary	land / Depa		Health and M	lental Hyg	iene 19. No. 2 A A E	(*) **a m m
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h 6-000	3Time of Death
	Physici /Medio		Alice E	Me	allin			Month 8	22 2005	7:20a M
	Examir		4a. Facility Name (If not institution, give :			,	or Location of Death		4c. County of Deat	
			241 Sandhill Ro				e River			more
	Funeral		5. Social Security Number 6. Sex	M OME	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		238-50-5686		73 Yrs.			6-8-3	32	N.C.
	/land		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Man a-f sh	to	MD Baltin	ore	Middl	le River				1 ∐Yes 2 🛣 No
	th the or 284	irec	10e. Street and Number	·		10f. Zip Code		10	0g. Citizen of What Co	untry?
	23e	Funeral Director	241 Sandhill	Road		21	221		USA	
	ar dea	nuel	The state of the s	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X lo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛂 No	Specify:		Specify:	Black
8	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show digal Eventinet be motthed at	edt	15. Decedent's Edu		16a. Dece	dent's Usual Occup	pation		16b. Kind of Business/	
215	nin 72 n "no Media	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ing		
21	d with	Completed by	6th			Cook	,		Private	Company
P	al Hy d oth	Be (17. Father's Name (First, Middle, Last)	Cools of			18. Mother's Nam	e (First, Middle, N		
yla	ould by Ment arke	2	John	Sykes			Dora		Love	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other then "neturel", or Items 23e or 28a-f show with jujury or other traumatic event, the Medical Event in trinual to notified at ance.		19a. Informant's Name/Relationship (Ty Darlene Walker	oe, Print) daughter					City or Town, State, Z	
	1 and Healtl em 27 ther t		20a. Method of Disposition				Road Mi		er, MD 20c. Location - City or	21221 Town State
Baltimore,	ages nt of l		1 X Murial 2 ☐ Cremation 3 ☐ R	emoval from State	Ob. Place of Dispo		Pk. 8/27		Randallsto	
Ħ	artme artme ortani injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	ne .		Name and Addre				21202
Ba	permi Depar Impol eny ir		by ladin	Wasse	C.		.H. East		imore, Md. E. North	
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, france, leading to more distances. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	ric Adex nsequence of):				on primau	Interval Between Onset and Death 2 months
68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	ical	resulting in death) Last	Due to (or as a co	nsequence of);					
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
	ss tha gned se det	by P	Part II. Other significant conditions con		t resulting in the u	nderlying cause giv	ven in Part I.		acco use contribute to	the cause of death?
ord	equire en si ould b	ted	Hypertension	1				1 🗆 Ye	s 2 No 3 Pro	bably 4 Unknown
Records,	e 2 sh	Completed by	Diabetes Me	litus				24a. Was ar autopsy	y prior to d	topsy findings available ompletion of cause of
H E	: The							perform 1 Yes 2	death? No 1 ☐ Yes	2□ No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	_	- Ott		h (Check only one		
of	ding Physicien: The lav n. After this certificate has funeral director, page 2	- T	1 ☐ Yes 2 ☑ No 27. Manger of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien	IL JUDON	4 🗀 (4d) 3 (1) 9 (1)	me 5 Reside 28d. Describe ho	nce 6 Other (Spec	ify)
on	ding th. : Afte	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	a <i>r)</i> Injury	Wo	rk?]Yes 2 □ No		,	
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	dical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the tivestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To th within Fo th	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
)		/	* Thomas SW	Osen M	OD.	D4	0277	A	usust 2	4,2005
1	47		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	Di il			
	/		Thomas S.W. 150		Signature	n Kave	m151va	ish thimo	ए 1110 21	257
	Sta Registi		31. Date filed (Month, Cay, Year) AUG 2 4 200	5 Beres	II An					

			1 - For State of Ma		nent of Health and I		2005 27700)
			Decedent's Name (First, Middle, Last)		ato or Boatin	2. Date of Death	3. Time of Death	_
	Physici /Medic		George	MADIAS	5-,	Avaust	21 2005 17 40 A	М
	Examin		4a. Facility Name (If not institution, give street and number)	1 (City, Town, or Location of Deatl		4c. County of Death	
			1110 00 10	PITAL	Baltimore 1	City		
	Funeral Director		5. Social Security Number 197 30 53 Lb 128M 2 F 7. Age Usual Residence of Decedent	(In yrs. last birthday) If U	Inder 1 Year If Under 24 Hrs. this Days Hours Min.	8. Date of Birth (Month, Day, You Detoner 20	9. Birthplace (State or Foreign Country) (Country) (Country)	gn
	land ow		10a. State 10b. County	10c. City, Town or Location	1		10d. Inside City Limit	ts
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow itest Examiner must be natified at	ţo	MD. Baltimore	Dundalk	4		1 ☐ Yes 2 🗷 N	lo
	or 284	Funeral Director	10e. Street and Number	10f	f. Zip Code	10g	. Citizen of What Country?	
	ath wi	al	3127 Wallford Drive	Apt. D.	21222		USA	
	er deg	nue	11. Marital Status 12. Was Decedent 8 Armed Forces?	If Yes,	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	rs afte	by F	1 Never Married 2 Married 1 7 Yes, C Ne 1 Yes, Give Year or Dates:	0 1 ☐ Y€	es 2 No Specify:		Specify: White	
21215-0036	tural		15. Decedent's Education	16a. Decedent's	Usual Occupation	161	b. Kind of Business/Industry	
215	within 72 ene. than "na	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give kind o	of work done during most of wor OT use retired)	rking		
21	filed with Hyglene. other ther	Completed	12 2		Leader	2	hemical Lompany	
Maryland	ed ital	Be	17. Father's Name (First, Middle, Last)		M	ne (First, Middle, Mai		
N N	d 2 should be the and Mental 7 is marked of traumatic ever	은	TETER MADIAS 19a. Informant's Name/Relationship (Type, Print)	19h Mailing Ado	dress (Street and Number or Ru	1	·	
Ma	har har 7 is		Tina Baker daughte	מתי מתוש	Jel Haven Rd.	Dundalk	2.000	
<u>o</u>	~ + 9 =		20a. Method of Disposition	20b. Place of Disposition cemetery, crematory	(Name of		c. Location - City or Town, State	
altimore,	00		1 BBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	2 1	emetery Avaus	23 2005	Dundalk Maryland	
alti	artm orts inju		21. Secature of Funeral Service Licensee		e and Address of Facility	me of Dun	dalk, RA.	
<u> </u>	Dep Imp		- Lug-	> 7110	Sollers Pt	Fd. Dund	1 at achan	- 19
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not enter the e.	mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	cardial in	Parction		Onset and Death	
	/Medical Examiner		Due to (or 3s	consequence of):	Ca 1 00			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	Talline			
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		annulitan in destal Lent	consequence of):				
8760,	cate be ohysici the bu	Physician/Medical	d					
9	eath certific attending pl	Med	IF FEMALE:	4				
Вох	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐ Ectop	or (specify)		23d. Date of delivery Month Day Year	
o.	at the de by the tached	ysi	1 Yes 2 No 9 Unknown 9 Unknown	3 O O O	(Specify)			
۵.	s that ned b e deta	by Pi	Part II. Other significant conditions contributing to death but	t not resulting in the underlyi	ing cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?	
rds	w requires been signi should be					1 ☐ Yes	2□No 3□Probably 4 Nunknow	m
of Vital Records,	e law requ has been je 2 shouk	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	le
E E		Com				performe	d? death? No 1 ☐ Yes 2 ☐ No	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			th (Check only one)		
of	Phys this al dir	2	1 ☐ Yes 25 No Hospital: 1 Inpatiel 27. Manner of Death 28a. Date of Injur		The state of the s	ome 5 Residenc	te 6 Other (Specify)	_
O	ing After une	tion	1 Natural 5 Pending (Month, Da) 2 Accident investigation	Year) Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred	
Division	il or Attending after death. Director: After In by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ry - At home, farm, street, far			et and Number or Rural Route Number,	
ā	i Sign	Certification:	4 - Homicide determined building, efc	(Specify)		City or Town, S	itate)	
	To the Hospital or within 24 hours after to the Funeral Direct completely filled in the funeral or the funeral filled in the funeral	edicai (29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medicel Examiner: On the basis of	examination and/or investiga	rred at the time, date and place	, and due to the caus	e(s) and manner as stated.	
	thin 2 the 1 the 1	Med	one) and manner sta 29b. Signature and Mile of certifier	ed.	29c. License number		Date signed (Month, Day, Year)	
	Z 1 1 2 2		1/1/10.10.		hantra	0 1	J rath >	_
,	T		30. Name and addre & of pe son who completed cause of de	eath (Item 23a) (Type Print)	1202441	7 17	MAUST LT CAO	5
E) .		Tuling C: Phone	1 600 N	V. Wolfest.	Bartima	emo. 21287	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Resistra	r's Signature			1.10	
	Registr	ar	AUG 2 4 2005	un B. Apo				

		State of Maryland / D	epartment of Health and M Certificate of Death	lental Hygie	
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Normal Moore 4a. Facility Name (If not institution, give street and number)	4.0	2. Date of Death Month 08 1	
Examine Funeral	er	Laurel Regional Hospital 5. Social Security Number 6. Sex	4b. City, Town, or Location of Death Laure Laure If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death Prince Georges 9. Birthplace (State or Foreign Country)
Director		2 4 6 - 2 6 - 0 4 4 0		04-19-	1926 North Caroli 10d. Inside City Limits
ith the Man or 28e-f sh	Director	MD Howard Coll	umbia 10f. Zip Code	100	1 ☐ Yes 2 🕍 No g. Citizen of What Country?
er death v items 23e	by Funerai I	6334 Cedar Lane 11. Marital Status 1 Never Married 2 Married **Widowed 4 Divorced** 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 No If Yes, Give Year or Dates: 1950 – 52	21044 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:		JSA 14. Race - American Indian, Black, White, etc. Specifia frican - American
77 75 1- 10	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	becodent's Usual Occupation Give kind of work done during most of worki life. DO NOT use retired) SECUTITY	ng 16	Private
d 2 should be filed th and Mental Hygi ?? is marked other treumatic event,	To Be	17. Father's Name (First, Middle, Last) MOSION 19a. Informant's Name/Relationship (Type, Print) 19b.	18. Mother's Name Amelia Mailing Address (Street and Number or Rura	Moore	
of Hea		1 X Burial 2 Cremation 3 Removal from State	r, crematory or other place)	ate 20	tinge M. 21207 c. Location - City or Town, State
permit. Page Department Importent: It any injury or once.		21. Signatur of Funeral Sende Licensee	9200 Liberty RD.	Randa	wings Mills, MD P.A. of Balto. C Ulstown,MD 21133
Physician /Medical		22a. Bart 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		r respiratory arres	t, Approximate Interval Between Onset and Death
be icia	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Chronic response to the condition of the condition	iratory & heart f	ailure	
± Se	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
hat id b	þ	Part II. Other significant conditions contributing to death but not resulting in Cardiovascular disease	the underlying cause given in Part I.		cco use contribute to the cause of death?
The ate has page	Completed				24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ XNo
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔏 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outp	26. Place of Death		ce 6 ☐Other (Specify)
i or Attending Phy after death. Director: After this I in by the funeral d	- 1	27. Manner of Death X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury 28b. Till (Month, Day Year)		28d. Describe how	
oitei or Attendurs after deathural Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	<u> </u>	City or Town, S	
To the Hospitei or At within 24 hours after or To the Funeral Direc completely filled in by	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, 2 ☐ Medicel Exeminer: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
To with	4	29b. Signature and title of certifier ACLE A BNM	29c. License number D0024364		Date signed (Month, Day, Year)
Stat	е.	31 Date tiled (Month Day Year) 1 32 Pegietrar's Signature	rel Park Drive #	225 Lã	urel, MD 20707
Registra	-	AUG 2 4 2005	God .		

			1 - State Amend Item Registrar	State of 21 per 1	Maryland H/G846	d / Depa ,08/2/	artmen Hillcat	t of H	ealth a Death	and M	ental Hy	ygiene Reg. No.	005	27702
	Physici /Medi	cal	Decedent's Name (First, Middle, La Sophia Manning 4a. Facility Name (If not institution, giv		har)		4h Cih	Tour	Location o	4 D 1h	2. Date of D Month AUSUS	Day	1,200c	3. Time of Death
	Examir	ner	GOOD Samantan 5. Social Security Number 6, S	Hospit	Age (In yrs. I	ast hirthday)	Bal If Under	time	Of Under		R. Data of R	N.	County of Dea	
	Funeral Director		- 1	□м Ж□ ғ	50	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D LO/20/	1954	MD C	thplace (State or Foreign ountry)
	Maryland -I show	tor	10a. State 10b. County MD Baltimor	e		r, Town or Lo Gwynn	Oak							10d. Inside City Limits 1 ☐ Yes ※ No
	with the	I Direc	10e. Street and Number 1102 Newfield Roa			owy III	10f. Zip	Code 2120 7	7			10g. Citiz	en of What Co	puntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumatic event, the Madical Evantral must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No			ent of His		gin? (Spec , Puerto F	cify Yes or N lican, etc.)	0- 1	4. Race - Ame Black, Whit	te, etc.
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene. Ither than "netur Int, the Modical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	dent's Usua kind of wor DO NOT us	rk done d se retired)	u <i>ri</i> ng most	of workin	g	Inte	grated	Health
ryland	should be file nd Mental Hy marked oth imatic event	To Be (12th grade 17. Father's Name (First, Middle, Last) Jasper McKo 19a. Informant's Name/Relationship (y					18. Mothe	etta		thews	Sumame)	
e, Ma	1 and 2 s Health an em 27 ls i ther treui		Sophia A. Carball				fount l	atte		. #20	3, Gwy	ynn O	ak, MD	21207
timor	ment of h		20a. Method of Disposition 1 □ Parial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specification)		. ce	ng Men	natory or or	ther place	08		¹ 2005		allstov	
Ball	permit. Departr Import. any inj.		21. Signature of Funeral Service Licer Vaughn C. Gr		DVR	Z Z Z	Name and Aughr	d Address n C. Balto	s of Facility Green Nat	ne Fu	meral like.	Serv. Balto	ice .MD 21	229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. COMP	ch line. CATION r as a conseque	Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
8760,	sate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	r as a consequ									
P.O. Box 6	I ne law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 🗆 Fetal ent at time of de	death 3□	Ectopic pre					23	3d. Date of del Month	ivery Day Year
rds, P	quires that an signed b uld be deta		Part II. Other significant conditions of Widely Metagfat	ontributing to dea	th but not resul	iting in the ur	nderlying ca	ause giver	n in Part I.			tobacco us	,	the cause of death?
		Completed by	Rectrictive Lu	ng Dis	ease						24a. Was auto perfo 1 - Yes	an psy prmed? 2 No	24b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of
vision of	After this funeral dir	Certification; To Be	25. Was case referred to medical examiner? 1	Hospital: 1 Mins 28a. Date of (Month,		R/Outpatien 28b. Time of Injury	28 M	A Other Bc. Injury : Work?	4 🗆 Nurs	sing Hom 28	d. Describe	dence 6 how injury		ral Route Number,
9	lo the hospitel of Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	vsicien: To the b	est of my know	ledge death	occurred a	at the time	o, date and	place, an	d due to the	021108(5) 2	nd manner as	stated.
)	vithin 24 To the F complete	Medical	29b. Signature and title of certifier	and manne	r stated.			License		. 55541190	at the time,		signed (Mont)	
	3 Sta	te	HAVPAL KHAM HA 31. Date filed (Month, Pak, Year)	ompleted cause	of death (Item :	1 RO	WELL	BI	vd, 5	nite	e, G1	BAI	Himor	e, MD 212391
	Registr		AUG 2 4 20	103	Esper Si	2 /								

Sephia Manning

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Penelope J. McKeldin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F Director 66 Yrs. 213-36-3777 July 10, 1939 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exampler must be multiped at MD 1 Yes 2 No Directo Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 C 117th Street 21842 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 XWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy Edward Sloffer Constance Margarite Coster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is in any injury or other traum once. Edward McKeldin/son 2505 Bounty Court Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ` 4 ∑Donation 5 ☐ Other (Specify) 21. Signature of Feneral Service License Ronal d. S. W. State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CNEUMON12 disease or condition resulting in death) /Medical Due t /(or as a consequence of): **Examiner** browchegenic CZICINOMZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death Year 5 Other (specify) P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: of Vital 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After t 28d. Describe how injury occurred Division 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 151C11/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Halbway Drive 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

AUG 2 4 2005

P660

8/20/2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Malcolm R. McNee 11, August 2005 2:15 PMM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deeth 601 Joan Drive California St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Days Hours Director 553-30-1529 77 July 6, 1928 California Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at Directo 1 ☐ Yes 2 ☐ No St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Joan Drive 20619 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 K] Yes 2 □ No If Yes, Give Year or Dates: 146-72 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be a Department of Health and Mental Important: If item 27 is marked o Malcolm Duncan McNee Virginia Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hunter McNee/son 601 Joan Drive California, MD

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20 20619 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or ° 4 \Donation 5 □ Other (Specify) S Wade, 21. Signature of neral Service Den 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final REA **Physician** CANCER resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the death certificate be executed and resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, TESas been si 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 1 ☐ Yes Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Momicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026064 08-19-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10583 THEODORE GREEN BLUD VIDYASAGAR ANMANGANDLA WHITE PLAENS, MD - 20695 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 4 2005 Registrar

		Ľ	1 - State of Maryland / Department Certification	ent of Health and Mate of Death	lental Hygie	2005	27705
	Physici /Medic		Decedent's Name (First, Middle, Last) CHARLES R. PORTER, SR.			Day Year 22, 2005	3. Time of Death 9:20PM M
7	Examin ———— Funeral	er	Upper Chesapeake Health H 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	ity, Town, or Location of Death arford der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	4c. County of Death Harford 9. Birth	n nplace (State or Foreign untry)
	Director		216~14~0575 XX M 2 F 83 Yrs. Month Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	ns Days Hours Min.	Nov. 11~		ryland
	ith the Marylan or 28a-f show e notility at	rector	Maryland Harford Belair ~	Harford County Zip Code	10g.	Citizen of What Cou	10d. Inside City Limits 1 Tyes 2 No untry?
036	after death w or Items 23a	by Funeral Director	1 ☐ Never Married 🗶 Married MXYes 2 ☐ No	21015 cedent of Hispanic Origin? (Spepecify Cuban, Mexican, Puerto		14. Race - Amer Black, White	ican Indian,
21215-0036	d within 72 hours jiene. r then "neturel", the Medical Exis	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade 15a. Decedent's U (Give kind of life. DO NO) 1ife. DO NO) Superv	work done during most of worki Tuse retired)	ng	Steel Indu	,
yland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic event, Ita Msone.	To Be C	17. Father's Name (First, Middle, Last) Joseph Porter	18. Mother's Name Effie	(First, Middle, Maid Tutchton	den Sumame)	
Baltimore, Maryland	1 and 2 sh Health and am 27 is m		Wayne M. Porter (Son) 2121 H	ess (Street and Number or Rura lampton Ct. Fal	lston, Md	, ,	
altimor	nit. Pages lartment of ortant: If It injury or o		XX Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) Parkwood Ce	metery 8-26	~2005 Ba	ltimore,	
Ba	permi Depa Impo any ir		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the management shock, or heart failure. List only one cause on each line.	Belair Rd. Ba		eral Home Md. 21236	Approximate Interval Between
68760,	Physician // Medical Examiner as the purial-transt	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Luc to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	STATE WITH	METS.		Onset and Death
P.O. Box	w requires that the death certifi been signed by the attending I should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other of the pregnant at time of death 5 ☐ Other of the pregnancy 2 ☐ Other of the pregnancy 3 ☐ Ectopic 2 ☐ Other of the pregnancy 2 ☐ Other of the pregnancy 2 ☐ Other of the pregnancy 3 ☐ Ectopic 3 ☐ Other of the pregnancy 2 ☐ Other of the pregnancy 3 ☐ Ectopic 3 ☐ Other of the pregnancy 2 ☐ Other of the pregnancy 3 ☐ Ectopic 3 ☐ Other of the pregnancy 3 ☐	c pregnancy (specify)		23d. Date of deliv Month	ery Day Year
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al Reco	: The law r cate has be ; page 2 sh		HYPERLIPIDEMIA		24a. Was an autopsy performed 1 ☐ Yes 2 2	? prior to co	opsy findings available impletion of cause of
Division of Vital Records,	physi this c	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No				fy)
Divis	To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)		City or Town, St	, , , , , , , , , , , , , , , , , , ,	
	To the Hospital or within 24 hours after Formaral Direction Completely filled in I	Medical	29a. Certifier (Check only one) 2☐ Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occurre	ed at the time, date a	and place, and due to	o the cause(s)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D45344	08	2/23/200	5
4	Sta Registra	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH DHANJAINI, MD, 6225 CNION 31. Date filed (Month, Day, Year) AUG 2 4 2005	AVE, HAVRE DE	GRACE ,	1021028	

		Registrar			Cei	rtificate c	of Death)	1	Reg. No.	200		2770
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7 Is marke treumetic		19a. Informant's Name/Relationsh		1	19b. Mailir	ng Address (Stre				er. City or	Town. State	a. Zip Co	ode)
z/ Is		Roberta Perki	ns (wife)										
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AUGUST 20, 2005 9:40 a.m.

LARRY PERKINS

Petroski Nellle Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physicia /Medic	al	Registrar Decedent's Name (First, Middle, Last, Nellie J. Pet	roski					2. Date Month Augus	t 22	2, 2005	3. Time of Death 12:59 A M
Examin Funeral Director	er	211-10-5659	ngton Med	dical e (In yrs. las 87		Glen B If Under 1 Year Months Days	urnie	er 24 Hrs. 8. Date (of Birth	Anne Ar Anne Ar 9. Bin 218 Penn	
Maryland	ctor	Usual Residence of Decedent 10a. Slate 10b. County Maryland Anne An	rundel	10c. City,	Town or Lo Sev	cation					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Depetment of Health and Mental Hygiene. Depetment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 7318 Musical Way 11. Marital Status	12. Was Decedent		. 13. \		144 Hispanic C	origin? (Specify Yes of an, Puerto Rican, etc	Uni	Citizen of What Co Lted Stat 14. Race - Ame	es erican Indian,
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2 should be and Mental le marked o aumatic eve	To Be	Anthony Auszura 19a. Informant's Name/Relationship (7)					Ne:	llie Unkn	own	y or Town, State, 2	Zip Code)
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To the Hospital or within 24 hours afte To the Funeral Dir.	edicai	29a. Certifier 1 Dizentifying Phy (Check only one)	sician: To the best ner: On the basis o and manner st	f examinatio	edge, death on and/or inv	n occurred at the ti	me, date a	and place, and due to eath occurred at the t	the cause ime, date a	(s) and manner as and place, and due	stated. to the cause(s)
~	Z	29b. Signature and title of certifier 30. Name and address of person who or	OC.	leath (Itam 7	in	29c. Licen	LTGS	4	29d. (Date signed (Monti	h, Day, Year)
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Registr	ar	AUG 2 4	2005	CARLO .	K. A	Second D			·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death Month Physician 2:300 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner 3606 Battimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** 32-768 1 M 2□ F Yrs Director Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ā 3606 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 ☐ Yes 2 ☐ No
if Yes, Give Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0,12) other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Max 2 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bal 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location -Department of important: If it any injury or o cemetery, crematory 1 Burial 2 Cremation 3 Removal from State Dulaney Valley ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License and Address of Facility 23a. Part1. Enter the dise se, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final prostate **Physician** cancer disease or condition 10 years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an page 2 s autopsy 2× No 2 No 1 🗌 Yes To the Hospitel or Attending Physician: After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 □ No Medical Certification: To 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funerel C
completely filled 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D D0056316 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Security Blvd. Baltimore, MD 2141 32 legistrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Maryla		artment of rtificate o			-	giene	000	27709
	Physic	ian	Decedent's Name (First, Middle, L	-					2. Date of De Month	eath Day	Year	3. Time of Death
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	Funeral			Sex 7. Age (In yr. 1 □ M 2 🕅 F	s. last birthday)	If Under 1 Yea Months Day		er 24 Hrs. s Min.	8. Date of Bir (Month, Oa	th ly, Year)	9. Bi	rthplace (State or Foreign country)
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	arylan ehow	_	10a. State 10b. County	10c. 0	City, Town or La	cation						10d. Inside City Limits
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	l and tealth			rty— Husband		Briarcl	liff I			ir, M	Marylar	nd 21014
Jor	Pages hent of hint; if its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State		natory or other pi	- 1		ate		ation - City or	
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	17	4	30. Name and address of person who	completed cause of death (Iter	п 23a) (Туре, Р	rint)	01	12.	12000	100	MAN	7. 2005
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	00-	- 6	1000	rirue	100	, VVIJ	2110
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Patent Known As Rose R. Syck

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×	nding use a	n/M	IF FEMALE: 23b. Was decedent	t pregnant 2	23c. ff yes, outcome			2 🗆 🗆					2	3d. Date of d	elivery	
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ecords,	w require been sig	Completed	HADE KUZIS	27 D: - 5c	tes Mellit	25	Scv.	x22-1	CW.	1	_	141	∕es 2.	140 2 I	Probably 4 Unknown	
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	r: The cate h: r. page												2 No	1 🗆 Ye		
A IE	Physician: The faw This certificate has trail director, page 2 s	o Be	25. Was case referr		lospital: 1 X fnpatie		D/O :		Oth			check only o				
5	Physical disparal di	\vdash	1 ☐ Yes 2 🗶 27. Manner of Death		28a. Date of Injur	v 2	8b. Tir	atient 3 D	28c. fnjun Worl	4 🗀 (4u) 5i		5 L. Hesid I. Describe h		Other (Sp	ecify)	
VISION	Attending r death, ector: Ater by the fune	ation	1 Natural 2 Accident	5 Pending investigation	(Month, Day	r Year)	Inji	M M		k? Yes 2 ☐ No	,					
<u> </u>	or desirector by the	ertification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju-	ry · At hom	ne, farn	n, street, factor	y, office		28f	Location (S City or Tow			Rural Route Number,	
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	Hosp 4 hou Funa tely fil	edicai	29a. Certifier (Check only	Certifying Phys	sicien: To the best oner: On the basis of	examination	ledge, on and/	death occurred or investigation	at the tin	ne, date and p pinion, death	place, and occurred	due to the dat the time, d	cause(s) date and	and manner a place, and du	as stated. We to the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death To the Funaral Director: After this certific completely filled in by the funeral director.	Med	one) 29b. Signature and	title of certifier	and manner sta	IBQ.		29	c. Licensi	e number			29d. Date	signed (Mai	nth, Day, Year)	
	- 3 - 8		1	111.	->>				_	5-000)					
1	NY		30. Name and addre	ess of person who co	empleted cause of de	eath (Item 2	23a) (T	ype, Print)					1720	st 21,	2005	
0)		Jenifer	C. Whea	ton, Do	Sir	16:	Leson L	of	Beller	سعدر					
No.	Sta		31. Date filed (Mont		32. Registra	ır's Signatu	re day	Pores	1							
	Registr	ar		AUG 2 4	ZUUD DE	SURE	250	To see a								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 13,2005 **Physician** NATHANIEL ROBINSON AUG. 5 М P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1721 Gorsuch Avenue BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthiplace (Country) APR. 22,1937 NEW YORK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 219-29 4327 Director 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show and be ruilling at 1 ☐ Yes 2 ☐ No Director N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1512 N. CAROLINE STREET or itams 23a 21213 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian, 11. Marital Status other traumatic avent, the Mudical Exercities ? Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) GARAGE Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 7TH SELF EMPLOYED MECHANIC Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHANIEL ROBINSON FRANCES WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DIANE ROBINSON (WIFE) 844 HARLEM AVENUE BALTO, MD. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Department of H Important: If Ite any injury or ot 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY 26,2005 BALTO, MD. nature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTRIC CANCER **Physician** MONTMS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner certificate be executed the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 🐼 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe (1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $_4 \square$ Nursing Home $_5 \square$ Residence $_6 \searrow$ ther (Specify) GARAGE1 Inpatient ၉ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Nathan A Switt I D0034484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATHAN A. SCOTT TO 1000 E. BAGGA ST. BALTIMORE MARYLAND 21202 GiM

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) AUG 2 4 2005

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistra Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20^{Day} Month 8 2005 **Physician** 10:40p M Stokes Linwood Logan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore NA Genesis Elder Care If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 8. Date of Birth (Month, Day, Year) 3-30-18 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1**X** M 2□ F Yrs. Va. 87 218-07-7052 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ral', or items 23a or 28a-f show Examinar must be notified at 1 XYes 2 No Director Baltimore NA Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 4812 Hamilton Avenue Apt. 2C IISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 XWidowed 4 □ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) other than Construction Baltimore City 5th grade 7 is marked othe treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Stokes Daisev Barner ပ Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Apt.2¢ 21206 Daughter 4812 Hamilton Ave., Baltimore, Md. Health Cynthia Barclay item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 8-26-05 Dundalk, Md. Mt. Carmel Cem. `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 1101 E. North Ave. March F.H. East wome 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Circon rumler Physician /Medical Due to (or as a consequence of): Examiner 750VV Sequentially list conditions, hany leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Attending Physicien: The law requires that the death certificate be executed Demento attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Discort amon He Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 3 No 1 Yes this certificate : After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification; To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attendir within 24 hours after death.
To the Funerel Director: All completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D 3146 8122101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N ENTAW ST 8mte 308 Baltimore MD 21201 2005 Registrar's Signature Boarde State Registrar

			1- For State of Maryland / Department of Health and No. Registrar Certificate of Death		iene	n =	27710
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Deat	h	Year	3. Time of Death
	/Medic	al	ROBERT EDWARD SMITH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	AUGUS		2005	11:25AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2806 GARRISON BLVD. BALTIMORE CIT		4c. County	N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
5	Director		312-12-8024 1XM 2□F 81 Yrs. Months Days Hours Min. Usual Residence of Decedent	12/25		IND	• *
	yland Now		10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	e Mar Ra-fsh	ctor	MD N/A BALTIMORE CITY				1 XYes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked othar than "natural", or itams 23e or 28a-f show any injury or othar traumatic avant, The Medical Evantiner must be notified at once.	Funeral Director	10e. Street and Number 2806 GARRISON BLVD. 10f. Zip Code 21216	10	0g. Citizen of	What Cour	try?
	ns 23	erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Rad	ce - Americ	an Indian.
9	after or ita		1 ☐ Never Married 2 ☐ Married Amed Forces? If Yes, specify Cuban, Mexican, Puerro If Yes, specify Cuban, Mexican, Puerro If Yes, Specify Cuban, Mexican, Puerro If Yes, Specify Cuban, Mexican, Puerro If Yes, Specify Cuban, Mexican, Puerro If Yes, Specify Cuban, Mexican, Puerro	Rican, etc.)		ck, White,	
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2	ad with	Completed	6TH College (1-4or 5+) AUTO MECHANIC		CORPO		OTORS ON
Maryland 21215-0036	be filk ntal Hy so oth avant	To Be	17. Father's Name (First, Middle, Last) JACK DANIEL SMITH 18. Mother's Name ELIZAB			,	
<u> </u>	should ind Men i marke umatic	Ţ	JACK DANIEL SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		ACKSON		Codol
	and 2 sho ealth and n 27 is mu		DELORES MALOCK / GODDAUGHTER 2806 GARRISON BL		-		
timore,	es 1 and of Health f itam 27 r othar tr				20c. Location		
Ĕ	Pages tment of I tant: If its jury or o		`4 □Donation 5 □Other (Specify) METRO CREMATORY 8/2				E, MD
Ba	permit. Page Department. Important: if any injury of once.		21. Signatur Funeral Service Licensee 22. Name and Address of Facility HO 4600 LIBERTY HEI				
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*	Physician		shock, or heart failure. List only one cause on each line/ Immediate Cause (Final disease or condition				Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of)				
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
o,	cate be executed ohysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
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JS,	The law requires that the tee base been signed by the base been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the	e cause of death?
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ita		Be C	25. Was case referred to medical 26. Place of Death			I □ Yes	2010
	Physic this ce	2		me 5 Pesider)
Division of	ding P.h. After funera	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	w injury occurr	red	
	f or Attendi after death. Diractor: A in by the fu	ifica	3 Suicide 6 Could not be	28f. Location (Stre	eet and Numb	er or Rural	Route Number,
ā	tal or A	Certification:	4 Homicide building, etc. (Specify)	City or Town,	State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a place of the course of the death occurred at the time, date and place, a place of the course of the	and due to the car ed at the time, da	use(s) and ma te and place.	nner as sta	ited. the cause(s)
	o tha ithin 2 o tha omplet	Med	one) and manner stated. 29b. Signature and title of certifier 7 29c. License number		d. Date signed		
-	F \$ F 8		1 20901A MD. 047405		8/22	105	•
1	37		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11 2 4	,	
	Sta	to	31. Date filed (Month, Day, Year) 32. Registr's Signature	noe /V/	0 4/1	01	
	Registr	-	31. Date filed (Month, Day, Year) 32. Records's Signature AUG 2 4 2005				

Amend item#29d, perME, G846m8/24/05 11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year GERALDINE F. STOGOSKI δ 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SQUARE Rosedale If Under 1 Year If Under 24 Hrs. FRANKLIN 7. Age (In yrs. last birthday) 11 MORE 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2XX Months Days Hours Min. Director 212-30-1415 70 Oct. 4,1934 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad othar than "natural", or items 23a or 28a-f shov traumatic evant, the Madical Examinar must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 8115 Edwill Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
II Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5-0036 White 1 Yes XXNo Specify à 3€Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 yrs. 17. Father's Name (First, Middle, Last) Insurance Co. 2 yrs. Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Frances Sowa John Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If itam 27 923 Corbett Rd. Monkton, Md. 21111 Gerard Das othar Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ital
any injury or oth 8-23-2005 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home 21. Signal re of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BILATERAL Pheumonia 6days /Medical Due to (or as a consequence of) Examiner Faily Keval unknown Sequentially list conditions, if any, leading to infline date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Completed by Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death ate of Injury (Month, Day Year) 28d. Describe how injury occurred FELL DOWN BASEMENT STAIRS Certification; 28b. Time of Injury Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 XNo 2 Accident 3 Suicide 8-13-2005 UNKNOWNM 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3115 COwill AUE. in by determined 4 ☐ Homicide Rosodale Mdi 21237 Home filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/19/2005 D005503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONAWAY 9000 FRANKIIN SQUARE DR. BAITIMORE Md. 21237 DR. JACQUES
31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 Registrar 4 2005

DHMH 17 Rev 1/2001

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Baltimore,

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Records.

of Vital

Division

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** ETHEL H. SCHMIDT /Medical AUGUST 20 2005 11:50AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GENESIS ELDERCARE-PERRING PARKWAY BALTIMORE COUNTY BALTIMORE 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M XXX Yrs Director PA 216~12~7830 Dec. 15.1920 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 7 is markad other than "natural", or Itams 23e or 28e-f shov traumatic avant, If a Modest Examiner must be multiled at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 101 Center Place Apt. 316 Funeral JSA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give 1 ☐ Yes 2√√No Specify Specify: White à X²√ Widowed 4 Divorced If Yes, Give Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. N/A 9 yrs. Clerical Hess Shoe Co. Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If itam 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ⊵⊮enry Bergman Alice Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Scott (Daughter) 600 Squire Lane Unit 2F Belair, Md. 21014 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or once. injury or ¹ 4 ☐ Donation Metro Crematory, Inc. 8-23-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Lassahn Funeral Home ann 7401 Belair Rd. Baltimore, Md. 21236 phon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Interpho /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a nonseduente of): Examiner The law requires that the death certificate be executed burial-transit Stons Istmal Palmayer Due to (or as a consequence of) Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 2 No or Attanding Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No funeral 28a, Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident in by the 1 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31464 MD 22/05

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Staller.

821 N. EUTAN ST Ante 308

BALTIMORE

MD 2/201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASHMI MD

AUG 2 4 2005

31. Date filed (Month, Day, Year)

			For Stata Ragistrar	State of Ma	aryland		artmen tificate		nd M	ental Hygiene							
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date o Month					Day Year				
	/Medic	al	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					18 2005 12 · 16 PM				
1	Examin	ier	Portusula Renional	ester	SALISBUM					Wicomico							
	Funeral		5, Social Security Number 6. Sec	1	e (In yrs. la		If Under Months	1 Year Days	If Under a	Ars. Min.	8. Date of Birt (Month, Day	h v. Year)	9	. Birthpla	ace (State or i	Foreign	
	Director		215-54-9276	56	Yrs.	Months Days Hours Mill.				January 1	19, 19	1949 Vermont					
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or					ocation 10d. Inside City Lin						Limits			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, It a Madical Examilist Coust be mutified at one.	5	Maryland Somerset Crisfield										2 🗌 No				
		rec						10f. Zip Code					l0g. Citizen of What Country?				
		a D	203 N. Somerset A	venue				21817					USA				
		Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc.				
36		by Fu	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:				1 ☐ Yes 2 ☒ No Specify:						Specify: White				
21215-0036			15. Decedent's Edu	16a, Dece	Decedent's Usual Occupation						16b. Kind of Business/Industry						
215		Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)							ng ,							
212		E O	12 Master Installer						r	Draperies							
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yla		2									clough						
Maryland			19a. Informant's Name/Relationship (T)		,		•	,				. ,			·	017	
			Jeanette M. Sillow 20a. Method of Disposition	way (Wite	20b. Pla	L COS I ace of Dispo metery, crer					- Cris		Cation - Cit			817	
Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		4	metery, crer .sbury			1	3/23/	'05 s	Salis	shurv	. Mā	aryland	Ē	
alti			21. Signature/of Funeral Service Licens		Pini						neral H		on all 1	, 110	ar y ranne		
m			Mary Beth Brac	Ishaw—Pru:	itt						- Cris		d, Ma	rvl	and 218	817	
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9		/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy										22d Data of delivery				
Box	atten after u	cian	23b. Was decedent pregnant in the past 12 months? 1									1	23d. Date of delivery Month Day Year				
P.O.	taw requires that the death as been signed by the atter 2 should be detached for u	hysi															
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E H	nding Physician: The law th. : After this certificate has I s funeral director, page 2 s										1 Yes	2 ₩ No			2 🗆 No		
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Division of Vital	or Attending siter death. Director: Afte in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In								Location (Street and Number or Rural Route Number, City or Town, State)					
	urs eft rai Di lled in	Cer	5 Suitains, State (Specify)														
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
	To the To the Comp	M	296. Signature and title of certified					29c. License number					29d. Date signed (Month, Dey, Year)				
	0	/	I yam Ur	m M.D.				00	6213	50		0	3/2	2/2	1005		
K	1		James Andia, M.D. 1104 Healthway Drive Salisbury, MD 21804														
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 4 200	37 Regist	rar's Signati	ure	de										

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			State Registrar		Cer	tificate of I	Death	2. Date of Dea	Reg. No.	005	2-7-7-17
п	Physicia	an	1. Decedent's Name (First, Middle, Last) Port Mil ton Chirls Cr					Month August	19,	2005	12:48 PM
	✓ /Medic	ai	Roy Milton Shirk Sr 4a. Facility Name (If not institution, give st			4h City Town or	Location of Death		7	ounty of Death	12.40 1
. 2	Examin	er	9946 Downsville Pi			Hager			1	lashingt	con
- 6"	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h (Year)	9. Birth	place (State or Foreign
	Director		217-12-2702	^{M 2□ F} 83	Yrs.	Months Days	Hours Will.	Sept 1	7,192		land
	pur 💃	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits
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	within 72 hours after deeth with the Maryland ene. then "neturel", or Items 23s or 28s-f ehow the Madical Examiner must be codified at	by Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	. 14	Race - Ameri Black, White	
98	or Its	y Fu	1 ☐ Never Married 2 🕅 Married	1 XYes 2 □ No If Yes, Give		1 □ Yes 2 No	Specify:			necify:	
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פָּ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden S	umame)	
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	t and teelth om 27 ther to		Rose M. Shirk / Wi				Dr. Hage	erstown Date		Land 21	
Baltimore,	permit. Pages 'Department of Himportant: If ite any injury or of 2000.		1 X Burial 2 ☐ Cremation 3 ☐ Re			sition (Name of matory or other placen Cemete		23 2005		,	,
Hin	artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen	a			ss of Facility Re				ano1
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	5		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death.							Approximate Interval Between
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9		ledi						October 177			
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	the att	sick	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dear 9☐ Unknown	th 5 🗆	Other (specify)				WOTE	Day . Sai
P.0	The law requires that the death certificate hes been signed by the attending page 2 should be detached for use es		Part II. Other significant conditions con	tributing to death but not resulti	ing in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
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	ours cours ours illed		29a. Certifier 1 Certifying Phys	ician: To the best of my knowl	edge, deat	the VS/45 h.	me, date and place	, and due to the	cause(s) a	and manner as	stated.
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	(Check only Medical Examinations)	ner: On the basis of examination and manner stated.	n and/or in	ivestigation, in my	opinion, death occu	irred at the time,	oate and p	piace, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	010		29c. Licens				signed (Month	
			1 Cahrello	XXX.	,		O.C.M.E.		Augus	st 21,	2005
	141		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type,	Print) Penn Str	reet, Bal	timore.	Marv	land 2	1201
	611		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		20111 001					
	St Regist	ate rar	On Date med (Month, Day, 19al)	32. Negistrar's Signatu		(d)					
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			For	State of Maryland / Department		ental Hygie	ene	
			State Registrar	Ce	rtificate of Death	Reg. 2. Date of Death	No.2005	2771.8
н	Physicia		Decedent's Name (First, Middle, Last)		NSKI	Month	Day Year	2343 DM
	/Medic	al -	ANTHONY 4a. Facility Name (If not institution, give s	<u> </u>	4b. City, Town, or Location of Death	AUGUST	4c. County of Death	~ 5
	Examin	C,	THE JOHNS HOPKIN		BALTIMORE CIT	Y		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birthr	place (State or Foreign
ь	Director		214-16-8336 1	(M 2 F Yrs.	Months Days Hours Min.	(Month, Day, 1	MAR	YLAND
	pu ,	ľ	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Le	acation		1	10d. Inside City Limits
	shov	5	MD BALTIM		VDALK			1 ☐ Yes 2 No
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	with be or		325 WISE	1112	21222		4.5.1	9.
	death	Funeral	407		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	city Yes or No-	14. Race - Americ Black, White,	
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	filed with Hygiene. other the ent, the h	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma		
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ary	2 shou and N is ma		19a. Informant's Name/Relationship (Ty	0 // / 0	ing Address (Street and Number or Rura	al Route Number, C	City or Town, State, Zip	
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Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ F	20b. Place of Disp cemetery, cre	osition (Name of omatory or other place)	626 m	c. Location - City or Te	
ij	Pa	١.,	* 4 ☐ Donation 5 ☐ Other (Specify)	St. SA	anislans 2	100.5 L	1.00	nD.
Bal	permit. Pages 1 and Depintment of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licens	1 AVIIVEL LOVE IS	2. Name and Address of Facility ONNELLY FUN	0-1-7	00 1341	DUNDOIK DMD21222
			23a. Part1. Enter the disease of compl	ications that caused the death. Do not er ne cause on each line.	iter the mode of dying, such as cardiac of	or respiratory arres	t,	Approximate Interval Between
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8760,	death certificate be executed e attending physician and id for use as the burial-transit	a E						
687	ficate p phys s the	edical		u				
Вох	leath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	
	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month	Day Year
P.0	that the de led by the a detached t	Phys	9 Unknown		and the same area in Part I	23a Did toha	cco use contribute to	the cause of death?
	w requires that the sbeen signed by th should be detache	b	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Fait i.	1 □ Yes	. .	bably 4 Dunknown
Vital Records,	requi	Completed				24a. Was an		opsy findings available
3ec	e la has	dm				autopsy perform	prior to co	ompletion of cause of
alF	icien: The certificate harector, page		25. Was case referred to medical		OC Please of Post			2 No
<u>Ş</u>		o Be	examiner?	Hospital: 1 Minpatient 2 ☐ ER/Outpatie	Other	h <i>(Check only one,</i> me 5 □ Residen	ice 6 Other (Speci	ifv)
of	g Phye er this eral di	 	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how		,
ion	Attending Phy or death. actor: After thi by the funeral of	atlo	1 Natural 5 Pending 2 Accident investigation		M 1 Yes 2 No			
Division of	or Atterde	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	urs af	Cel		To the best of an investment of the	Athenan data and place	and due to the one	eco(c) and manner as	etatod
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledical	29a. Certifier (Check only one) Certifying Phy Certifying P	/sician: To the best of my knowledge, dea iner: On the basis of examination and/or i and manner stated.	investigation, in my opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	A 0.75	29c. License number		d. Date signed (Month	
	2		1 ME	WD	RES- OPP	Av	GUST 22,	2005
	6			completed cause of death (Item 23a) (Type STO LIDES 600 A	a, Print) NORTHE WOLFE STREET	RAITMOO	= MD 21	287
	St	ate	31. Date filed (Month, Day, Year)	32. Recentrar's Signature		, 1011-111101	1	
	Regist	rar	AUG 2 4	2000 person 10.	The state of the s			

CPM 05-05673 Gorden Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		í	For State Registrar		State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of I</i>			giene Reg. No.	05	27719
	Physici	an	1. Decedent's Name	(First, Middle, Las	,	Alexander	Smith		2. Date of Dea	Day	2005	3. Time of Death
	/Medic		4a. Facility Name (If r	not institution, give		Alexanuei	1	r Location of Death	August		inty of Death	08:18 a™
~			4049 Brun				Pasad	ena If Under 24 Hrs.			ne Arur	
	Funeral Director		5. Social Security Nur 219-26-6 Usual Residence of D	121	7. Age	67 (In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birt (Month, Da)	h, Year) 6, 1937		place (State or Foreign ntry) Maryland
yiand	Mow M			10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
e Mar	Be-f el	ctor	Maryland		Arundel		Pa	asadena				1 X Yes 2 □ No
with th	a or 2	Funeral Director	10e. Street and Numb	-			10f. Zip Code	21122		10g. Citizen	of What Cour U.S.A	•
death	ems 23	nera	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No	14. F	Race - Americ	can Indian,
IIIQ KIKIS-0000 be filed within 72 hours after death with the Maryland	it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-f ehow or other traumatic event, the Madical Examiner must be notified at	þ	1 Never Married 3 Widowed 4		1 □Yes 2 □ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☐ X No	Specify:	7 110411, 010.7			Black
12 h	"netu adisal	ietec		5. Decedent's Ed only highest gra		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of worl	king	16b. Kind o	f Business/In	dustry
With L	r then	Completed	Elementary/Second	dary (0-12)	College (1-4or 5	+) """		e Digger			Ceme	tery
D ed	d other	Be	17. Father's Name (F		D. 0#-			18. Mother's Nam				
should	and Mental Hygiene. ie marked other then aumatic event, the Me	유	19a. Informant's Nam	the second	B. Smith	19h Maili	ng Address (Street	and Number or Ru		la B. Sm		Code)
and 2 s	aith an 27 io ar trau		Peggy Bon		,,,,,		3 Hoyle Road				m, olate, Esp	, 6000)
	Department of Health a Important: If item 27 is eny injury or other tra		20a. Method of Dispo		Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	:e)	Date		on - City or To	
it. Pe	ntmen ortant: njury		4 Donation 5	Other (Specify			Ille Veterans C		08/31/05	(Crownsvil	le, Md.
Derin D	Depa Impo		▶ Lfle	rud	951			rothers Fune utaw Place, E	ral Service	d 21217	-	
			23a. Part1. Enter the shock, or heart	dis se, or comp failing. List only	olications that caused one cause on each lin	death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	nysician Medical		Immediate Cause (Fi disease or condition resulting in death)	inal	a Other	vilente	ancho:	y culy	Dise	m		Onset and Death
	xaminer				Due to (or as a	a consequence of):						
Q	ii.	iner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	litions, nediate ving	Due to (or as a	a consequence of):						
xecute	and al-trans	Examiner	that initiated events resulting in death) La		cDue to (or as a	a consequence of):						
icate be exe	physicien and is the burial-transit	cal		·	d							
A CO	ling ph	9	IF FEMALE:		20-1/	,		<u> </u>				
the death c	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	onths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
quires that	n signed b			ent conditions co		ut not resulting in the u	nderlying cause give	en in Part I.			ontribute to the	he cause of death?
The law rec	te has bee age 2 shou	Completed by								med?	prior to con death?	opsy findings available impletion of cause of
clan:	ertifica ector, p	BeC	25. Was case referred	}-				26. Place of Dea	(V	2 No	1 es	2 1 10
Physic C	rthis or	၉	1√ Yes 2 No	0	Hospital: 1 ☐ Inpatie			4 Nursing H	ome 5 Resid			SCENE
nding .	ath. r: After e fune	ation	1/ Natural 2 ☐ Accident	5 Pending investigation	(Month, Day	Year) Injury	Worl	k?` Yes 2 ☐ No	200. 2000100 1	ow injury occ	341100	
ai or Atte	s after deal of Directo of in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (S City or Tow		mber or Rura	al Route Number,
ie Hospii	n 24 hour he Funer oletely fills	edicai	29a. Certifier 1 (Check only one)	☐ Certifying Ph	ysician: To the best of iner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the dired at the time, of	ause(s) and date and plac	manner as si ce, and due to	tated. o the cause(s)
Tot	withii To th	×	29b. Signature and tit	le of certifier	11.1		29c. License			_	ned (Month,	
	-7		30 Name and address	eodire .	U King	ath (Item 22a) (Tura		.C.M.E.		_	st 23,	
	2				ompleted cause of 9	ath (Item 23a) (Type,	Penn Str	eet, Balt	imore,	Maryla	nd 212	201
ě	Sta Registr		31. Date filed (Month,	Day, Year) 2 4 2005	7 32. Registra	r's Signature	<i>(e)</i>					

		1	State of Maryland / Department of Health and Me State of Maryland / Department of Health and Me Registrer State of Maryland / Department of Health and Me Registrer Certificate of Death	ental Hygien Rag. N	2005 27720
	Physicia	n		Date of Death	ay Year 8:10 f M
	/Medic Examin		A. Facility Name (If not institution, give street and number) 2007 W. 4b. City, Town, or Location of Death BON SECOURS HOSE ITAL BALTIMORE ST. BALTIMORE	4	c. County of Death
Ī	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F F F Yrs. 1 M 2 F F F Yrs. 1 Months 1 M 2 Min. 1 Min.	8. Date of Birth (Month, Day, Yea 6/3-4/10	
	a-f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltmore Dundal K		10d. Inside City Limits 1 ☐ Yes 2 12 No
	h with the 23a or 28	Funeral Director	7836 St. Bridget LN 2/222		Citizen of What Country?
036	within 72 hours after death with the Maryland one. Than "natural", or items 23a or 28a-f show the Maylical Ezamither must be molified at	þ	11. Marital Status 1	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0	vithin 72 ho ne. han "natur e Mudical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DONOT USE		Kind of Business/Industry Teamster
Maryland 21215-0036	should be filed w and Mental Hygier s marked other th umatic event, III	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	1 '
-	1 and 2 Health a em 27 ls ther tra		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19c. Mathed of Disposition 20b. Place of Disposition (Name of	LN. Du	v or Town, State, Zip Code) Nda IK, MD 2/222 Location - City or Town, State
Baltimore	permit. Pages Department of Important: If it any injury or o		22a. Name and Address of Facility 21. Signatur of Funeral Service Liceosee 22. Name and Address of Facility 23. Facility 24. Signatur of Funeral Service Liceosee 25. Name and Address of Facility 26. Rame and Address of Facility 27. Signatur of Funeral Service Liceosee	Funera	Balto, MD I Home, P.A.
	Pnysician /Medical Examiner	10	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):	r respiratory arrest,	Approximate Interval Between Onset and Death SUAUS
8760,	cate be executed oblysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
	w requires that been signed by should be deta	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIA (VETES MELLITUS	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 □ Probably 4 □Unknown
Division of Vital Records,	sician: The law req certificate has beer irector, page 2 shou	Completed by	DEMENTIA	24a. Was an autopsy performed	
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? Hospital: Mississ 2 SER/Outsitest 3 Dood Other: 4 Dissipated to the control of the		C DOther (Specific)
n of	> 00	on: To	1 Yes 2 ye No	28d. Describe how in	6 ☐Other (Specify)
Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Homicide 6 Homicide 128e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	e Hospita 24 hours te Funeral	Medicai C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier JANET V. MOCHBELIMD. 29c. License number D14949	8	Date signed (Month, Day, Year)
(le	2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GON SECOUNS IN SOUTH IN THE TOWN WE BALTIMON F	ST. BALTI	mant MD 21223
41	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 4 2005 32. Egistrar's Signature		

DHMH 17 Rev 1/2001

AUGUST 19,

		•	1- State Amend Item 7 State Registrar	Peps Cer	riment of Heatificate of De	alth and M eath	ental Hyg	iene g. No.2 0 (95	27722
16.	3/4 . 5	Secretary	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		EUGENE W. SLACUM				AUG.21		1001	3:16P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County	of Death	
	3,09	A Comment	4909 GOODNOW ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	BALTIMO	ORE Under 24 Hrs.	8. Date of Birth	N/a		place (State or Foreign
	Funeral Director		215-28-3511 10M 20F 737-2	Yrs.		Hours Min.	(Month, Day,	132	Cou	TIMORE, MD
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Lo	cation		/ /			10d. Inside City Limits
	Maryli f sho	or								1X Yes 2 No
	28a-	Director	MD . N/A 10e. Street and Number	_BA	LTIMORE 10f. Zip Code		1	0g. Citizen of V	Vhat Cou	intry?
	ath with 23a o		4909 GOODNOW ROAD		21206	õ		U.S.A	A .	
	ams serum	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hispa Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)		e - Ameri k, White,	can Indian, , etc.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itams 23a or 28a-f show other treumatic event, the Medical Exanting must be notified at	by Fu	t X Never Married 2 ☐ Married 1 X Yes 2 ☐ No 1 X Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		☐ Yes 2☐XNo S	Specify:		Specify	BLA	CK
21215-0036	2 hou		15. Decedent's Education 16		lent's Usual Occupatio			16b. Kind of Bu	ısıness/lr	ndustry
215	within 72 ene. than 'nai	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done duri OO NOT use retired)	ing most of worki	ng			
	e filed within al Hygiene. I other then '	Con	4 years	CLE						OFFICE
and	ntal H	Be	17. Father's Name (First, Middle, Last) WILLIAM SLACUM		18	3. Mother's Name HELEN	,,,	maiden Sumam	θ)	
Maryland	2 should be and Mental is marked eumatic ev	ဥ		b. Mailin	g Address (Street and			City or Town,	State, Zi	o Code)
∑	nd 2 s lith ar 27 is r treu		LUTHER C. SLACUM (COUSIN)	140	WINSTON	JAVE	BALTO.	MD. 2	123	0
Ē,	item 27		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of natory or other place)			20c. Location -	City or T	
imo	Pages nent of ant: If it ary or o		1 Deurial 2 Cremation 3 Hemoval from State	-		VETERA		OWÍNG	SM	ILLS, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. A chature of Funeral Service Licensee	C22	Name and Address of ALVIN B.	SCRUG	GS FUN	ERAL H	OME	1213
V.			23a. Part1. Enter the disease, or complications that caused the deeth. Do shock, or heart failure. List only one cause on each line.	not ent						Approximate Interval Between
j	Physician		Immediate Cause (Final disease or condition	41	elier Q	The state of the s	dara	\$7		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a ponsequence	e of):	-41	47	1 o'			
**		-e	Sequentially list conditions, if any, leading to immediate b. Due to (gr as a gonsequence	e of):	U HER	Vo To	The contract of the contract o	~		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ter	Sin					
oʻ	sician and burial-transit		resulting in death) Last Due to for as a consequence	e of):						
8760,	cate be e. ohysician the buria	dicai	d			· · · · · · · · · · · · · · · · · · ·				
9	ertifica ling pl	Med	IF FEMALE:							
Вох	requires that the death certificate een signed by the attending phys hould be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Dat Mo	e of deliv	ery Day Year
o.	that the de led by the a detached t	nysic	1 Tyes 2 No 4 Pregrant at time of death 9 Unknown	3_	Other (specify)					
Δ.	ires that signed b d be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause given i	in Part I.	23e. Did tob	acco use conti	ribute to t	the cause of death?
rds	w requires been sign should be						1 □ Ye	s 2□No	3 r ol	babiy 4 □Unknown
Records,	aw as b	Completed					24a. Was a autops	v .	Nere auto	opsy findings available ompletion of cause of
Œ E	The ate h page	Corr					perform	ned?	death?	
Vital	Physician: This certificated director, p	Be	25. Was case referred to medical examiner? Hospital:		Othor	6. Place of Death				
of	Phys this al dir	٦.	1 Tes 2 Iz No	outpatien . Time of	The state of the s	4 Nursing Ho	ne 5 🗆 Reside 28d. Describe ho			fy)
on	ding I h. After funer	tion	1 DNatural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work?	s 2 □No	200, 2000, 20 110	m mjary occan	00	
Division	of or Attending after death. Director: After din by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (St City or Town		er or Rur	al Route Number,
ā	tal or rs afte el Dira ed in b	Cert	4 Notificial				City of Town	, 3(4(4)		
	To the Hospital or At within 24 hours after of the Funeral Direct completely filled in by	Medical	29a. Certifier 1 (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death and/or in	occurred at the time, restigation, in my opini	date and place, ion, death occurr	and due to the ca ed at the time, d	ause(s) and ma ate and place, a	nner as s and due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License ni	umber	2	9d. Date signed	(Month,	Day, Year)
	. 0		Lashua Metchell	45	DO	878.	2	8/2	3/0	05
j	11/		30. Name and didress of person who completed cause of death (Item 23a	(Type,		2 0	.35.	35	2	17 \ 117
	Sta	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	10. 220	00 15	(1) 56,	20/0/	_ (Ds	The Jew
ķ	Regist		AUG 2. 4. 2005 Person &	· No	falls					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Amend	l Item	State of I	Marylan me G8	d / Dep 46 8 2	artment of F 24-05 tas	lealth and N Death	Mental Hyg	iene	07700
			Decedent's Name (/							2. Date of Deat		3. Time of Death
	Physici		KATHL	EEN	TU:	BMAN				AUGUST	18 2005	9:19AM
	/Medic Examir		4a. Facility Name (If no	ot institution, gi	ve street and number	er)		4b. City, Town, o	r Location of Death	1	4c. County of Dea	th
					ROAD, A		211	GWYNN			BALTIM	
	Funeral		5. Social Security Num		Sex 1 □ M 2XX 7.	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	rear) . Co	thplace (State or Foreign ountry)
Н	Director		Usual Residence of De	719		81	113.			8/9	1/24 N.	CAROLINA
	yland Now			0b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28a-f show	tor	MD	BALTI	MORE		GWYN	N OAK				1 ☐ Yes 2 XNo
	or 28)ire	10e. Street and Number					10f. Zip Code		10	0g. Citizen of What Co	ountry?
	ath w	ral	6800 LI	BERTY	ROAD, A			2120			USA	
	ltams	nue	11. Marital Status		12. Was Decede Armed Force	s?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
36	hours after death with the Maryland tural', or Itams 23a or 28a-f show at Examiner must be multiled at	by Funeral Director	1 ☐ Never Married 3 🔀 Widowed 4 (_	1 ☐ Yes 21 If Yes, Give Year or Date	X X° .s:		1 ☐ Yes ३₽ No	Specify:		Specify: R	LACK
21215-0036	72 hours "natural",		15	5. Decedent's 6	Education	1	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	
215	within 72 ene. than "nat	Completed	(Specify Elementary/Seconds		rade completed) College (1-4)	or 5+)	(Give life.	kind of work done DO NOT use retired	during most of world)	king		
21	ad wit	Com	12тн	, (- , -,			HEAL	TH DEPA	RTMENT		GOVERNME	NT
nd	ba filed tal Hygi d othar event, L	Be	17. Father's Name (Fit						18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)	
Z	2 should ba filed withir and Mental Hygiene. Is markad othar than aumatic event, ILEMS	Ţ	CONNIE	WIGG					VIOLA			
Maryland	12 sh h and 7 is n		Albert T	ubman/s JONES	ON NIECE		6800	Liberty	Rd., Apt.	.514°, NuBari	City or Cown, Sta MI	D 21207
	s 1 and 2 should ba filed within 72 hours after death with the Maryla of Health and Mental Hygiene, itam 27 is markad othar than "natural", or Itams 23a or 28a-1 show itam 27 is markad othar than "natural", or Itams Locardified at othar traumatic event, the Medical Exerment nast Locardified at	1 3	20a. Method of Dispos		/ NILCE	20b. P	lace of Dispo	isition (Name of		Date :	ORE, MD 20c. Location - City or	7 1 2 4 4 Town, State
nor	Pages nent of I		XIX Burial 2 □0	Oremation 3	Removal from Sta	1 C	emetery <u>,</u> c <u>re</u> i	on atory or other place ON CEM.	8/2		•	E CO., MD
Baltimore			101	ral Service Lice) 2:	2. Name and Addre	ss of Facility LT	OWELL E	TINEDAT U	OME 21207
B	permit. Departr Imports any inje		> // /w	Tune.	1/1.1	(Sill	The 4	600 LIB				TIMORE, MD
			23a. Airt1. Zhier the	sease, or con	mplications that cause on each	sed the death						Approximate Interval Between
	Physician		Immediate Cause (Fir		Lh1	h 1	21. 11					Onset and Death
	/Medical		disease of condition resulting in death)		Due to (or	s a consequ	uence of):	O V V			-	
	Examiner		Sequentially list condi	itions.	b							
	sit s	Examiner	cause. Enter Underly Cause (Disease or injury	ing 4	Qualto (or	ве в попеаці	ilerice oty:					
_	and I-tran	хап	that initiated events resulting in death) Las		c. Due to (or	as a consequ	uence of):					
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687	ficate physics the t	edical			d							_
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outcome						23d. Date of de	livery
	death e atte	icia	in the past 12 mg	onths?	4□Pregnan	n 2∏Fetal t at time of de		Ectopic pregnancy Other (specify)	/ 		Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown		9□ Unknow	n						
	uires tha signed d be del	by F	Part II. Other significa	nt conditions	contributing to deat	h but not resu	ulting in the u	nderlying cause giv	ren in Part I.		acco use contribute to	
ord	w requir been si should	ted		4 kul	inallu	<u>, a</u>				1 🗆 Ye	s 2 No 3 P	robabły 4 Dunknown
Records,	ne law r has be ge 2 sh	ple	Olu	exilis	V					24a. Was ar autops	y prior to	utopsy findings available completion of cause of
E R	The cate h	Completed		U			1			perform	ned? death? No 1 ☐ Yes	2 No
/ita	Physician: r this certific ral director,	Be	25. Was case referred examiner?	to medical	Hospital:			Oth		th (Check only one		
of	Physical this call directions	2	1 Yes 2 No)	1 Inp.		ER/Outpatier 28b. Time o		4 🗆 Nulsing A	ome 5 seside 28d. Describe ho	nce 6 Other (Spe	cily)
UQ	ding h. Aftar funar	tlon	1 Natural	5 Pending	28a. Date of I (Month,	Day Year)	Injury	Wor	yai k? Yes 2 □No	200. Describe no	w injury occurred	
Division of Vital	Attandii death. ctor; A y the fu	fica		6 Could not	be 28e. Place of	Injury - At ho	me, farm, st	eet, factory, office			eet and Number or Ri	ural Route Number,
Β̈́	alor A after I Dirac d in by	Certification;	4 🗌 Homicide	detellillile	building,	etc. (Specify	1)	,.		City or Town	, State)	
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Diractor: Attar this certificate ha completely filled in by the funaral director, page		29a. Certifier 1	Certifying F	hysician: To the be	st of my know	wledge, deat	n occurred at the tir	me, date and place,	, and due to the ca	use(s) and manner as	s stated.
	the Ho in 24 the Fu	Medical	(Check only 2[one)	Medical Exa	aminer: On the basi and manner	s or examinat stated.	ion and/or in	vestigation, in my o	pinion, death occui	rred at the time, da	ite and place, and due	o to the cause(s)
	To To To To To	≥	29b. Signature and titl	e of certifier	land.			29c. Licens	_	29	od. Date signed (Mont	h, Day, Year)
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	3			NESH	2323 (DRUE	INS	Print) STREET,	POALT.	[MORE	, MD 21	224
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				. For	State of Ma		d / Depa	artment of H	lealth and			-	27721
				State Registrar			Ce	rtificate of	Death		Reg. No	- 000	6116.4
		Physicia		Decedent's Name (First, Middle, Last ADELAIDE EMMA TI	" HIEMEYER					2. Date of De Month AUGUS	Day	2005	3. Time of Death 5:05 P M
		/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Deat	h	4c.	County of Death	1
				WESLEY HOME				BALTIMOR			BA	ALTIMORE	
		Funeral Director		5. Social Security Number 6. Se	x 7. Ag □ M 3√√x 9		last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		th Year	910 Mar	place (State or Foreign intry) yland
		yland now		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
		the Mar	Director	Maryland Baltimor	e	To	owson-	Baltimor	e County		10g. Cit	izen of What Co	1 ☐ Yes 2 ☐ No untry?
		with the I	Ö	730 Camberly Circ	16			2120)4	1	·	JSA	
		death	lera	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Decedent of H		Specify Yes or No)-	14. Race - Amer Black, White	
Pm	336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other treumatic event, the Medical Examinat must be notified at	Completed by Funeral	XXX Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes XX No		to ritoan, etc.)			ite
5:05	21215-0036	in 72 ho	oleted	15. Decedent's Ed (Specify only highest grad		5.)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo d)	orking		ind of Business/I	
10	212	e filed within at Hygiene. other than avent, the Me.	E O	Elementary/Secondary (0-12)	N/A	5+)	Во	okkeeper			В.	& O. Rai	lroad
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1	Maryland	2 sho		19a. Informant's Name/Relationship (7				ng Address (Street					
205		1 and 2 Health is tem 27 I		Robert L. Stockso	ате	20b. F		Rock Spi osition (Name of matory or other pla		Date		ocation - City or	
2	סנ	Pages nent of h int: If ite		X⊠Burial 2 ☐ Cremation 3 ☐	Removal from State	'				1~2005	Dal-	timono	Maryland
0	Baltimore,			 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		Pa	Contract to the Contract of th	Cemetery 2. Name and Addre		assahn f			
8/20/2005	Ba	permit. Departr Importe any inju		> E. 7. Less	ahn			7401 Bela					
(/0				23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that cause one cause on each l	d the deal	h. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
0		Pnysician / /Medical		disease or condition resulting in death)	a. EN D-	27A	GC of):	CARDIDI	MYD (ATI	47		-	YCHRS
ari		Examiner			ALTERIO	Sell	arott C	CARDIOI	VASCUL	AR D	1SEV	tse	YUARS
Pl			je L	Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	uence of):			*******			
EXPIPED		te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
)	760,	e execian a		resulting in death) cast	Due to (or as	a consec	quence ot):						
	6876	cate b	dica		d								1000
R		leath certificate b attending physi of for use as the b	/Me	IF FEMALE:	23c. If yes, outcome	e of pregn	ancy					23d. Date of deli	very
THIEMEYER	P.O. Box	Physicien: The law requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			□Ectopic pregnanc □ Other (specify) _	У			Month	Day Year
Z		that the de led by the detached	y Ph	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
16	Records,	w requires that been signed to should be det	Completed by	PROGRESSIVE 7	DEME NTI	4				10	Yes 2	□No 3□Pr	obabiy 4 Unknown
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1		The la	mo							perf	ormed? 2 X No	death?	2□ No
	ital	hysicien: The law his certificate has b I director, page 2 s	Be C	25. Was case referred to medical examiner?						eath (Check only	one)		
DE	of Vital	Physic this ce al dire	To	1 ☐ Yes 2 No	Hospital: 1 □ Inpat		ER/Outpatie	int 3[] DUA		Home 5 ☐ Res			cify)
		ing P	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time Injury	Wa	iryat ork?]Yes 2 ☐ No	28d. Describe	now inju	ry occurred	
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FDELAI	Division	or A after Direc	Certification;	4 ☐ Homicide determined	building,	tc. (Speci	fy)	root, ractory, crisco		City or To	wn, Stat	θ)	
F		To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Ph	ysiclen: To the bes	of examin	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time	cause(s date an	and manner as d place, and due	stated. to the cause(s)
_		To the within 2 To the complet	Med	29b. Signature and title of certifier	7 /				se number			ate signed (Monti	
		- S - Ö		* Kole JE. Y	Colym	D.		D-1	9425		08	-21-2	005
		2	1	30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type	, Print)	•	0			21209
	Y)			OBY M.D		2/1 h	1- ROGET	25 AVE	- BALTI	moR	E, MD.	21209
		Sta Regist	ate	31. Date filed (Manth Pay, Year) 20	05 Regis	trar's Sign	Albire A	and				,	

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I		Reg	ene . No 2 (1 (1 (5	27725
	Physici	an	Decedent's Name (First, Middle, Las Ramona Thompson					2. Date of Death Aug.	23 2005	9:00 a. M
). * ;	/Medic Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Dea	
**	Funeral Director		217-28-7315	3/-V-	e (In yrs. last birthday 32 Yrs.) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	ear) C	thplace (State or Foreign ountry) aryland
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits
	ith the Marylar or 28a-f show	ctor	MD Carrol	.1	Finksb					1 □Yes XXNo
	with the	Funeral Director	10e. Street and Number 2105 Bethel R	đ.		10f. Zip Code	21048	100	g. Citizen of What C U . S	-
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	. Was Decedent of If Yes, specify Cub		pecify Yes or No-	14. Race - Ame Black, Whi	erican Indian,
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is merked other than "natural", or items 23c or 28e-f show or other traumatic event, it a Modical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married XXVidowed 4 ☐ Divorced	1 □ Yes XXX N If Yes, Give Year or Dates:	40	1□Yes X IXNo	Specify:		Specify: W	hite
15-(in 72 h	olete	15. Decedent's Ed (Specify only highest gra	de completed)	(Ĝive	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wor ed)	rking	6b. Kind of Business	/Industry
212	filed withi Hygiene. Ither than	Completed	Elementary/Secondary (0-12)	College (1-4or 5		sembly_	Worker		Manufac	turing
pug	be file Ital Hy od oth event	Be	17. Father's Name (First, Middle, Last) Robert Dempst	er Ander	son			ne <i>(First, Middle, Ma</i> ie Margu		illman
Maryland	2 should be f and Mental H is merked of sumatic ever	ပ	19a. Informant's Name/Relationship (7			ling Address (Stree		ral Route Number, (
	1 and 2 s Health ar Iem 27 is		Elaine McLaug						•	
Baltimore,	Pa ant ury		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disp cemetery, cre New Oal Church	osition (Name of ematory or other pla cland Cemeter	y 8/2		Sykesvil	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	4	E	ekinard todi	uneral C	hapel P.A.		
t	***		23a. Part1. Enter the disease, or comp	olications that caused	the death. Do not er					Ma. 21117 Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each in) STAGE	Demen	1 (2)			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	, , , , ,				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
8760,	cate be executed ohysician and the burial-transit	ical Ex	resulting in death) Last	Due to (or as	a consequence of):					
P.O. Box 6	The law requires that the death certificate be executed as been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of de Month	livery Day Year
	ss that gned b	by PI	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba		o the cause of death?
ord	w require been si should I	ted	- Hypertene					1 ☐ Yes		robably 4 🗹 Unknown
Records,	has b	Completed	0200000	b				24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
tal	ician: Th certificete rector, pag	d)	25. Was case referred to medical				26. Place of Dea	1 Yes 2 Inth (Check only one)	JV6 1 ☐ Yes	3 2 No
of Vital	Physician: this certific al director,	To B	examiner? 1 Yes 2 No		ent 2 ER/Outpatie		her: 4 🗆 Nursing H	lome 5 siden	ce 6 □Other (Spe	ocify)
Division o	ding h. After funer	Certification;	27. Man of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	-		M 1	rk?]Yes 2 □ No	28d. Describe how	injury occurred	
Divi	after d after d Direct d in by	ertifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C			of my knowledge, dea f examination and/or i ated.					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/	/	29c. Licen	se number	290	I. Date signed (Moni	th, Day, Year)
1	2	-	In to	/	1	1200	50 76	3	8/23/1	
1)	H	30. Name and address of person who	ndoza	leath (Item 23a) (Type	Realisto	ke Rd	Wast,	minste	, mD215
ą.	Sta	ate	31. Date filed (Month Day Year)	2005 32. Apist	ar's Signatur					

ככנ	1)9		_	State of	of Marvla	and / Depa	artment of H	ealth and	Mental Hyg	giene			
			For State	otato .			rtificate of L			Reg. No.	0 =	0 ***	
			Registrar 1. Decedent's Name (First, Middle	Last)				-	2. Date of Dea		U5	3. Time of	Death()
	Physici	an	Dulani		S.E.		Watk	ins	August	Day,	2005	5:40	Ам
	/Medic		4a. Facility Name (If not institution				4b. City, Town, or			4c. County	v of Death	7	
4	Examin	er	University of Ma			Center	Baltim		, au		V/A		
			5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 H	Irs. 8 Date of Birt			lace (State o	or Foreign
	Funeral Director			1₩ 2□F	31	Yrs.	Months Days		Irs. 8. Date of Birt in. (Month, Day		Cour	itry)	, , orong,
			220-86-9862 Usual Residence of Decedent		31				11 13	73	P	1D	
	yland yow		10a. State 10b. County		10c.	City, Town or Lo	ocation				1	0d. Inside Ci	ty Limits
	Mar	tō	MD NA			Baltime	ore					X CXYes	2 🗌 No
	128e	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	itry?	
	3a o		AEEI Dan Ing	u Bood			21	229		U.S	S.A		
	within 72 hours atter death with the Maryland liene. r then "natural", or Items 23a or 28e-f show the Madisal Examiliar must be conflied at	Funeral	4551 Pen Luc 11. Marital Status	12. Was Dec	cedent Ever i	n U.S. 13.		spanic Origin?	(Specify Yes or No-	14. Ra	ce - Americ		
9	after or Its	Ē	1 Never Married 2 Marri	ied 1 ☐ Yes	20 No		il res, specily cuba 1 □ Yes XIXNo	Specify:	erto Alcari, etc.)				
8	ral',	l by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:		TE TOS ALATO	эрвспу.		Specit	^{ry:} Bla	ack	
5	72 hc	Completed	15. Decedent (Specify only highes)	(Give	dent's Usual Occupa	during most of v	working	16b. Kind of B	Jusiness/Ind	dustry	
2	within 72 ene. then "nat	n de	Elementary/Secondary (0-12)	Ţ	(1-4or 5+)	life.	DO NOT use retired)		., .			
7		Cor	12th grade	na		La	borer			Manufa		ring	
pu	tal Hyg d othe	Be	17. Father's Name (First, Middle,				1		Name (First, Middle,		пе)		
<u>X</u>		P	Barrymore W.						J. Mille				
Maryland 21215-0036			19a. Informant's Name/Relations						Rural Route Number	•			220
	C = N L		Linda J. Wat	kins-Mo				aca St	reet, Ba				230
ore	5 to 1		20a. Method of Disposition ty⊡yBurial 2 ☐ Cremation	3 Removal from			matory or other plac	1		20c. Location			
Ē	Pages ment of I		t Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	K				/27/05	Randa.	llst	own,	Md
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	Licensee			2. Name and Addres						_
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			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.							Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition	Mu	Hiple	gunsho	t avound	's wit	the compli	cation	S	Oriset and t	Jeann
	/Medical		resulting in death)	Due to	o (or as a con	sequence of):							
	Examiner		Sequentially list conditions.	b									
	ים פ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to	o (or as a con	isequence of):							
	acute Ind trans	am	that initiated events resulting in death) Last	с									
Ö,	e exe sien a uriat	Ω	resulting in death) Last	Due to	o (or as a con	sequence of):							
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9	leath certific ettending p	Mec	IF FEMALE:										
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		birth 2 1	Fetal death 3	Ectopic pregnancy				ate of delive onth	,	Year
	the e	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□ Unk	gnant at time nown	of death 5[Other (specify)					,	
P.0	that the d ed by the detached	Physician/Me		and contribution to	doath but not	requities in the .		an in Dant I	220 Did #	obacco use con	atabuta ta ti	an cause of c	doath?
	res tha	þ	Part II. Other significant condition	ms contributing to	ugain bui noi	. resulting in the t	indenying cause givi	en in Part I.			3 ☐ Prob		Jnknown
of Vital Records	w requir been s should	Completed						-	- 101	65 20110		abiy 4 🖂	- INCHOMI
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<u> </u>		5								rmed? 2 ☐ No	de ih?	2 🗆 No	
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place of I	Death (Check only o	ле)	17		
<u>></u>	Physic this of	ုင	1X Yes 2 □ No			2 ER/Outpatie		4 LI NUISIN	g Home 5 ☐ Resid			y)	
	ng P fter t inera	ü.	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date	e of Injury onth, Day Yea	28b. Time of Injury	Wor		28d. Describe	now injury occu	rred		
Division	Attending in death.	Certification:	2 ☐ Accident investig	gation +/3/	105	Formed 22		Yes 2 No	Sucjec	+ 540	+		
Ξ	after d Direct	Ě	3 ☐ Suicide 6 ☐ Could determ	100d 200, Flat	ce of Injury · / ding, etc. (Sp	pecify)	reet, factory, office	,	28f. Location (S City or Tox	vn, State)			
	itel or af		ļ			5 (40				Athol A	. ,		e, HD
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2X Medical	Exeminer: On the	basis of exar	knowledge, deat mination and/or in	th occurred at the time execution, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and m date and place,	anner as s , and due to	tated. the cause(s	;)
	ths hin 2 ths mplet	Med	one)		nner stated.		29c. Licensi	a number		29d. Date signe	ad (Month	Day Year!	
	To You	-	29b. Signature and title of certifie		10-			C.M.E.		August	1		
			/ Cabrill	led 4			0.	· · · · · · · · · ·		11ugust			
	100	~	30. Name and address of person	who completed ca	use of death					. 1 1	01.00	1	
	U_{\perp}		CABICICON	HH				et, Bal	timore, Ma	aryland	2120	 T	
	Sta		31. Date filed (Month, Day, Yeer)	0005	Registrates S	Signature	Sparke						
	Regist	ar	AUG	2 4 CHO	A STATE	1000	B						

Patrant known as Richard Williams Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760.

				or Print in Blac			•	•	
			1 - State Registrar	e of Maryland / I	Department of F Certificate of			ene g. №2 Ո Ո ⊏	27727
#	Physici		Decedent's Name (First, Middle, Last) Richard		Williams	Īν	2. Date of Death	Day Year ZO	3: Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street an	CD 1.	4b. City, Town, o	or Location of Deat		4c. County of Dea	
	uneral irector		5. Social Security Number 6. Sex 212-26-2608 Usual Residence of Decedent	7. Age (In yrs. last bit				9. Bir 28	rthplace (State or Foreign ountry) MD
Manyland	-f show	tor	10a. State 10b. County MD NA	10c. City, Tow Balt:	n or Location i more				10d. Inside City Limits 1 √ Yes 2 □ No
ith the	or 28a	Director	10e. Street and Number	I,	10f. Zip Code		10	g. Citizen of What C	ountry?
filed within 72 hours after death with the Maryland Hydiene.	"natural", or Iteme 23a or 28a-f show solical Extraorer count by notified at	Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. ed Forces? Yes 2 □ No s, Give	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (San, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	U • S • 14. Race - Am Black, Whi	erican Indian,
hours	al Ex	ed by	3 ₩ Widowed 4 ☐ Divorced Year 15. Decedent's Education	or Dates:	. Decedent's Usual Occur		1	6b. Kind of Business	Black
within 72	od other than "ne event, the Madis	Completed	(Specify only highest grade completed in the complete in the c	eted) ege (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of wor	rking		,
Hvoie	other	Be Co	12th grade na 17. Father's Name (First, Middle, Last)		Owner	18. Mother's Nar	ne (First, Middle, M	Mortons aiden Surname)	Mover's
should be	Is marked other than aumatic event, It s M.	ToB	Richard Williams S			Lucy F	owkles		
d 2 sh	27 Is m traum		19a. Informant's Name/Relationship (Type, Print		o. Mailing Address (Street				Zip Code)
ages 1 and of Heal	Importent: If Item 27 is marked any injury or other traumatic e once.		Nathaniel Jones-Soi 20a. Method of Disposition 1 Parial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State 20b. Place o	LO6 Leight Disposition (Name of ry, crematory or other pla	сө)	Date 2	Oc. Location - City or	
rmit. P	Importen any Injur once.		21. Signature of Funeral Service Licensee	Garri	22. Name and Addre	ss of Facility	8/30/05	Owings	Mills, Md
) දීරී	E = 8		Almette K	· Jones	March F/ 4300 Wab	ash Ave	, Balti	nore, Md	21215
	sician edical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	par gast	rontesta	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	miner			e to (or as a consequence	of):				
ecuted	transit	amlner	cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence	of):				
be execu	icien and burial-tra	E	that initiated events resulting in death) Last c	e to (or as a consequence	of):				
ificate	g physias the	edlo	d						
Attending Physicien: The law requires that the death certificate be excited att.	by the attending physicien a stached for use as the burial-	Physician/Medical	in the past 12 months?	s, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐Ectopic pregnance 5 ☐ Other (specify) _	y		23d. Date of de Month	livery Day Year
s that	igned b be deta	by Pt	Part II. Other significant conditions contributing	to death but not resulting i	n the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
requir	been si		hypertons; on				1 🗆 Yes	2 □ No 3 □ P	robably 4 Munknown
The law	has ye 2	Completed	prostate cano	ar			24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
icien:	99	Be	25. Was case referred to medical examiner? Hospital:		strationt 3 Doa Oth	oc	th (Check only one		
g Phys	er this eral di	n: To	27. Manner of Death 28a. I		Time of 28c, Injur	4 🗆 Ruising F	lome 5 Residen 28d. Describe how	ce 6 □Other (Spe injury occurred	city)
tendin eath.	or: After the funer	catlo	2 Accident investigation	Monin, Day Fear)		Yes 2 □ No			
itel or Att	To the Funerel Director: A completely filled in by the tr	Certification:	determined 286.	Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
the Hospitel or	e Fune letely fi	edical	29a. Certifier 1 Certifying Physicien: T (Check only one) 2 Medical Examiner: On and	o the best of my knowledge the basis of examination an manner stated.	e, death occurred at the tire ad/or investigation, in my o	me, date and place prinion, death occu	, and due to the cau irred at the time, dat	se(s) and manner a e and place, and due	s stated. e to the cause(s)
To th	To th	Me	29b. Signature and title of codifier		29c. Licens	e number	290	d. Date signed (Moni	h, Day, Year)
75)	1		10		Da	06273	6 A	ugust 7	20,2005
UY.	10		30. Name and address of person who completed Matthau Sa	cause of death (Item 23a)	(Type, Print)	so: tal	of R	altmo	th, Day, Year)
*	Sta Registr		31. Date filed (Month, Dan 106) 2 4 200!	32. Regien, r's Signature	T. Agreement				1 💆

DHMH 17 Rev 1/2001

			1 - For State Registrar	,	partment of Health and ertificate of Death	Mental Hygie	0 0 0 m
P			Decedent's Name (First, Middle, Last)		or Boarn	2. Date of Death	3. Time of Death
	Physici /Medic		Alice	С.	Wattie	8 1	6 2005 17:01 ^b
	Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Dea	th	4c. County of Oeath
· K			4025 Frederick A 5. Social Security Number 6. Sex	Avenue #102 7. Age (In yrs. last birthda	Baltimore V) If Under 1 Year If Under 24 Hrs	8. Date of Birth	N A
	Funeral Director		219–30–0576		Months Days Hours Min		9. Birthplace (State or Foreign Country) Va.
	pu »		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location		10d. Inside City Limits
	Manyla f sho	ō	Md. NA	Too. Only, Town of	Baltimore		Y Yes 2 No
	r 28e	irect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	th with	al D	4025 Frederick Av	venue #102	21229		USA
36	77 hours after death with the Maryland "neturel", or items 23s or 28e-f show pulsal Executations the relitied at	by Funeral Director	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces? Yes 2 17/10 es, Give ar or Dates:	3. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
9-0	2 hou	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occupation ve kind of work done during most of wo	16t	o. Kind of Business/Industry
21215-0036	I within 72 ho iene. r then "netur the Medical	Completed		lege (1-4or 5+)	. DO NOT use retired)	n king	
	be filed w tal Hygier d other ti event, III		8th grade 17. Father's Name (First, Middle, Last)		Domestic 18. Mother's Na	me (First, Middle, Mai	Other People Homes
Maryland	be od o	To Be	McKinley	Shelton		.ma	Wattie
lary	and and ie m		19a. Informant's Name/Relationship (Type, Prin		iling Address (Street and Number or R		
	s 1 and 3 if Health item 27 other tr		Leon Lucas 20a. Method of Disposition		3935 Lowndes Ave		ore, Md. 21218 c. Location - City or Town, State
nor	a 0 .		1 🖁 Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	Lfrom State cemetery, ci	rematory`or other place)		Suitland, Md.
Baltimore,	그 든 뿐 등		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		ore, Md. 21202
ä	Depar Impo eny ir		I lady W	ane	March F.H. East		. North Ave.
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not e se on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MYDCARDI.	AL INFAR	CTION	
F_{j_1}	Examiner			oue to (or as a consequence of): HYPERTEN	sim		
	₽ #	iner	cause. Enter Underlying	us to (or as a consequence of):	A		
	and and I-trans	Examiner	that initiated events c.	Due to (or as a consequence of);	MELLITUS		
68760,	icate be executed physician and s the burial-transit	cal E	d	HYPER	LIPIDEMIA		
-		fedical	U				
). Box	The law requires that the death certific to has been signed by the attending p tage 2 should be detached for use as:	Physician/M	in the past 12 months?		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the ed by detach		Part II. Other significant conditions contributing	ng to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	quires tha n signed ald be del	d by	OBESITY			1 🗆 Yes	2 No 3 Probably 4 Donknown
CO	aw requir ts been si 2 should l	Completed	ARTHRITI	S (OSTEO)	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
I R		Com				performed	death?
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	ath (Check only one)	
of	Phys this ral din	1: To	1 Tes ZIIINO	Date of Injury 28b. Time		Home 5 Residence	e 6 Other (Specify)
ion	ttending F death. ctor: After y the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No		
Division	or Attend after death Director:	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, state)
	pitel c		200 Contition 4 Theretical Physician	To the best of my knowledge de	ath a second of the second of the		-(-)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examiner: Or		ath occurred at the time, date and plac investigation, in my opinion, death occ		
	To th withir To th comp	Me	29b. Signature and title of certifier	- 110	29c. License number		Date signed (Month, Day, Year)
	\mathcal{N}		· Ramo Shanka	/	D0048		8-22-05
1	Y		30. Name and address of person who complete RAMA SHAWKAR.	d cause of death (Item 23a) (Typ	1501 Division	UST R	MN 21217
	Sta		31. Date filed (Month, Day, Year) AUG 2 4 200	32. Registrar's Signature	Soule		
	Registr	ar	MOU & 4 LOG	- July College			

		_	For	State of Marylar	•			lental Hygie	ene	
			State Registrar		Ce	rtificate of	Death		1. No. 1) 1) 5	27729
	Physicia		Decedent's Name (First, Middle,					2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic	al	Lewis Vernon Wa 4a. Facility Name (If not institution,			4h City Town o	or Location of Death	08	20 2005 4c. County of Dea	
	Examin	er	4017 Klausmier			Baltir			Baltimo	
	Funeral			3. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		rthplace (State or Foreign ountry)
	Director		215-07-2636	¹XM 2□F 86	Yrs.	Months Days	Hours Min.	10/14/19	918 Ma	ryland
	and	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Aaryis f sho	ō								1 ☐ Yes 2X No
	the N	Director	MD Balti 10e. Street and Number	more E	altimo	10f. Zip Code		100	g. Citizen of What C	ountry?
	3a or		4017 Klausmier	· Road		21236	5		U.S.A.	
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	
စ္တ	or Ite	교	1 Never Married 2 Marrie	d 1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2 ☒ No		Thousand Order	Specify:	no, otc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modical Exama nor must be modified at	d by	3 Widowed 4 Divorced	Year or Dates: WW		dent's Usual Occur		14		ite
7	n 72 "nat	Completed	15. Decedent's (Specify only highest	grade completed)	(Give		during most of work	ring	so. Kind of business	undustry
7	filed withi Hygiene. Ither than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pur	chasing A	Agent	н	utzler Br	
פ	e filed Il Hygid other vant, L	Be C	17. Father's Name (First, Middle, La	ast)	·			e (First, Middle, Ma		
<u>Ja</u>	should be ind Mental s marked c umatic ave	To E	Fred H. Walter	Special regions of the contract of the contrac			Barbara	a Blucher		
Maryland	2 sho and is mu		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ing Address (Street	and Number or Rui	al Route Number, (City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, the Mydical Examination at Indiffed at once.	1.	Alice Marie Wa 20a. Method of Disposition			Klausmie	er Road -		e, Maryla Oc. Location - City o	
Baltimore,	Pages hent of Hant: If its		1 XBurial 2 ☐ Cremation 3	3 □Removal from State	cemetery, cre	matory or other pla	се)			
┋	permit. Pag Department Important: I any injury c once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li	DC.		Luth. Ch. C	Lem. 08/2	4/2005 E	Baltimore	Maryland
Ba	Depa Impo any is	82.	10 90 X	Passalai						al Home, P.A. rland 21087
			23a. Part1. Enter the disease, or c shock, or heart failure. List or							Approximate Interval Between
	Pnysician	06 9	Immediate Cause (Final disease or condition		nal c	Micar	cinoma	of the h	ladder	Onset and Death 20 mon #15
	/Medical Examiner		resulting in death)	Due to (or as a consec				. , ,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Examine	Ļ	Sequentially list conditions,	b. Due to for as a cons	wanaa afir					
	led nsit	nlne	cause. Enter Underlying Cause (Disease or injury	Due to for as a conse	guerroe org.					
	execunand and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ate be executed hysician and the burial-transit	call	(d						
9	rtifical ng phy as th		ICCEMALE.							
Вох	ith ce tendii or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feti		⊒Ectopic pregnanc	y		23d. Date of de Month	Day Year
C.	The law requires that the death certifics ate has been signed by the attending ph bage 2 should be detached for use as t	Physician/Med	1 Yes 2 No	4☐Pregnant at time of e	death 5[Other (specify) _			, income	Suy Su
P.O.	that the	Ph	Part II. Other significant condition	s contributing to death but not re	sulting in the u	underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records,	uires tha signed Id be del	d by	colon concer v	resection 2/1	4/200	5		1 Yes	2 No 3 F	robably 4 Unknown
COL	w require been si should I	lete	hypertension					24a. Was an	24b. Were a	utopsy findings available
Re	The la te has age 2	Completed	-107001 (1010101)					autopsy performs	prior to death? No 1 □ Ye	completion of cause of s 2 No
ital	iician: Th certificate rector, pag	o l	25. Was case referred to medical				26. Place of Dear	th (Check only one)		
_	Physician: r this certificanal director, is	To B	examiner? 1 ☐ Yes 2 No		ER/Outpatie	nt 3□ DOA Ott	her: 4 Nursing Ho	ome 5 Residen	ce 6 □Other (Sp	ecify)
u o	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe how	injury occurred	
Sio	Attending ir death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no		iomo form el]Yes 2□No	28f Location (Stre	et and Number or F	Rural Route Number.
Division of Vital	i 를 를 드	Certification;	4 ☐ Homicide determin	building, etc. (Speci	fy)	reet, factory, office		City or Town,		iara riodio nambo,
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the			Physician: To the best of my kn						
	the Ho nin 24 h the Fu	edical	(Check only 2 Medical E	xaminer: On the basis of examin and manner stated.	ation and/or ir	nvestigation, in my	opinion, death occur	red at the time, dat	e and place, and du	e to the cause(s)
	Vithii Vithii To th	Ň	29b. Signature and title of certifier	\		29c. Licen:			d. Date signed (Mor	
,	1/4	7	1 Vsege	i, my		000	051349		8/22/20	
6	31		30. Name and address of person w		m 23a) (Type Lin Sq	. Print) ware Driv	e Svite 20	5 Baltiv	nou, MD 2	1237
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature					
	Registi	ar	AUG 2 4 2	1005 Banco	Y Por	3129				

			1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment of ertificate of	Health an <i>Death</i>	d Mental Hyg	iene 19. No. 2005	27730
	Physici		1. Decedent's Name (First, Middle, Las Stephen Joseph	Warminski				2. Date of Deat Month August	Day Yeer	3. Time of Death 9:15p M
	/Medio Examin		4a. Fecility Name (If not institution, give Woodlands Assist			4b. City, Town, Essex	or Location of D		4c. County of Death Baltimor	
	Funeral Director		5. Social Security Number 218-10-7273 6. S	9x 7. Age (In 1	yrs. last birthday Yrs.) If Under 1 Yea Months Days		Hrs. 8. Date of Birth (Month, Day, Sept 24	9. Birtl Co 1916 Md	nplace (State or Foreign untry)
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Maryl a-f sho	tor	Md Carroll		Sykesvil					1 ☐ Yes 2 ☐ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itema 23e or 28a-f show about, I'm Medical Examinational be notified at	al Director	10e. Street and Number 5806 Victor Dr	ive		10f. Zip Code 21784		1	og. Citizen of What Co USA	untry?
_	ter deat Itema 2	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No	r in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, P	? (Specify Yes or No- querto Rican, etc.)	14. Race - Ame Bleck, White	
200	Junel', or	þ	3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 📆 No	Specify:		Specify: whi	·-
Maryland 21215-0036	ithin 72 t ne. han "natu Nedica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retir	e during most of	f working	18b. Kind of Business/	ŕ
17 p			17. Father's Name (First, Middle, Last)	4	tea	cher	18. Mother's	Name (First, Middle, M	educati Maiden Surmame)	on
yian	2 should be and Mental is marked or raumatic sve	To Be	Stanislaw Warmin	ski			Johann	na Luckstei	n	
Z	is 1 and 2 should of Health and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relationship (Joanne Soter (dau					or Rural Route Number, ${\sf Kesville},\ {\sf M}$		(ip Code)
Baltimore,			20a. Method of Disposition 1 Description 3 Cremation 3 Cremation 3 Cremation 5 Country 5 Co	Removal from State		osition (Name of ematory or other pl of Faith			20c. Location - City or	Town, State
Balti	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licer Page Daight	1	P	2. Name and Addi	ess of Facility 195 Syke	Haight Fune esville, Md	ral Home & 21784	Chape1
表	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the one cause on each line. a	pira	the mode of dy		sum and		Approximate Interval Batween Conset and Death S— (O Clay)
8760,	ate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co						
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of deli Month	very Day Year
	juires that n signed b	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause g	iven in Part I.		acco use contribute to	
Vital Records,		Completed	Advanud	Demon	ha,	Chron	c Kidu	24a. Was ar autops perform 1 Yes 2	y prior to d	topsy findings available completion of cause of
	Phyaician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA	ther	Death (Check only one	/	:4.1
Division of	ding Phy h. After this funeral d	\vdash	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Inju	4 U NUISII	ng Home 5 Reside		anyj
DIVISI	after deal Director:	Certification;	3 Suicide 6 Could not be determined		At home, farm, si Specify)	treet, factory, office)	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or in	th occurred at the nvestigation, in my	time, date and p opinion, death o	place, and due to the ca occurred at the time, da	suse(s) and manner as ate and place, and due	stated. to the cause(s)
)	To the To the comp	Me	29b. Signature and title of certifier	MD -		29c. Licer	-38 j	7-54	9d. Date signed (Month $08-19$	21225
	10		30. Name and address of person who MALIKA W	ASBBM	700	Print) PAST	BRN	BUD.	MD-	21225
l	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 4 2005	32. Registrar's	Signature	W				

			1 - For State Registrar	State of Maryland		artment of H			71115	277	31
			Decedent's Name (First, Middle, Last)			incate or i	Joan	Reg. 2. Date of Death	_	3. Time of	Death
	Physici /Medio		William 1	4. WIRGINS				August 2	2,2005	4:15	AM
	Examin		4a. Fecility Name (If not institution, give s	street and number	_	4b. City. Town, or	Location of Death		4c. County of Death		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Place (State or	r Foreign
	Director		240-40-6211 18	M 20F 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye TUNE 20	1930 Cou	ntry) NC	, or digit
	and www.		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Cown or Lo	cation				10d. Inside Cit	rv Limits
	Mary I sho	tor	MD Balti	more.	SIA	balk				1 🗆 Yes	. /
	or 284	Director	10e. Street and Number	, ,		10f. Zip Code		10g.	Citizen of What Cou	ntry?	
	sath w		271 St. He	leva NVe.	110.1		1222	-# WN-	U.S.A. 14. Race - Ameri	1	
ယ	or Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 1 19 es 2 No Koreo	24/		ispanic Origin? (Spe in, Mexican, Puerto F	Rican, etc.)	Black, White,		
21215-0036	d within 72 hours after death with the Maryland jiene. I than natural; or Items 23a or 28a-f show the Medical Esandmer internative motilied at	d by	3 Widowed 4 Divorced	Year or Dates: War		I□Yes 200 No	Specify:		Specify: WX	112	
15-	in 72 t	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done o DQ NOT use retired	during most of working	9 166	. Kind of Business/In	dustry	
212	od within giene. ar than "	Som	Elementary/Secondary (0-12)	College (1-4or 5+)		boiler i	Yaker	De	thlehen	Stee	1
pu	ld be filed ental Hygi ked othar ic event, t	Be	17. Father's Name (First, Middle, Last)				18 Mother's Name	(First, Middle, Maid	den Sumame)		
Maryland	should the and Mental target and Mental target and Mental target and the sumatic of the sumatic	ဥ	19a. Informant's Name/Relationship (Ty)	1991NS	19b. Mailir	a Address (Street	and Number or Rural	Houte Number Cit	ry or Town, State, Zip	Code)	
Ma	s 1 and 2 should f Health and Men ltam 27 is marke other traumstic		Teresa Bardru	00	860.	/	ING tON	Rd By	homes m	1 2/2	36
ore	0 0 = =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		e of Dispo etery, crer	sition (Name of natory or other place	e) D	ate 20c	. Location - City or To	own, State	
Baltimore			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Tar.	KWE	d Cemek	48/2	4/05 Ca	thmore,	MA	
Ba	permit. Departr Importa any inji		21. Signature of Fullerar Service License	tela	3	Name and Address	- ASh ton	Funera	1 Home	12 P.A.	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cau the death. It is cause on each line.	Do not ent	er the mode of dyin		respiratory arrest,		Approximate Interval Betw	veen
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	105	tali	Car	ncer		6	Onset and D	path)
E	/Medical Examiner		resulting in deality	Due to (or s a consequen	ice of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	nce of):						
	ecuted and -transi	Examine	that initiated events resulting in death) Last	Due to (or as a consequen	100 of):						
8760,	ate be executed hysician and the burial-transit	dicai E		Due to (or as a consequen	ice oi).						
9	tificate ig phys as the	0									
Box	leath certifica attending ph I for use as t	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3	Ectopic pregnancy			23d. Date of delive		'ear
0.	the the	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	h 5□	Other (specify)			10001111	Day 1	ou.
s, P	es that the igned by be detact	by Ph	Part II. Other significant conditions con	tributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.	23e. Did tobaco	o use contribute to the	ne cause of de	eth?
ords	w require been sig should b							1 Yes	2 □ No 3 □ Prob	oably 4 🗆 Ur	nknown
of Vital Record	aw Is b	ompieted						24a. Was an autopsy	24b. Were auto	ppsy findings a mpletion of ca	vailable iuse of
la		e Co	25. Was case referred to medical				OC Diana of Danish	performed	? death? No 1 Yes	2 No	
Ψ	S S	To B	evaminer? A	ospital: 1 Inpatient 2 ER	/Outpatien	0the	26. Place of Death One of Death Nursing Hom		6 ☐Other (Specif	y)	
	ing Pr		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work		8d. Describe how in	njury occurred		
Division	il or Attanding after death. I Diractor: After I in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	. farm. str		Yes 2 □No	Bf. Location (Street	and Number or Rura	Il Route Numb	per
Div	tal or / rs after al Dira ed in b	Certification;	4 Homicide determined	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, St	ate)		
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Phys Certifying Phys Certifying Phys	ician: To the best of my knowled ier: On the basis of examination and manner stated.	and/or inv	estigation, in my op	pinion, death occurre	d at the time, date a	and place, and due to	the cause(s)	
	To the within 2 To tha I complet	Me	29b. Signature and high of certifier			29c. License	number	2 9 d. (Date signed (Month,	Day, Year)	
	10		> jundlet			DY	2422	18	22/15	_	
4	$\sum_{i=1}^{N}$		30. Name and address of person who co	mpleted cause of death (Item 23	(Type,	7/2 N/	chad	01 5	464-	7/234	6
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 1	costs	- 10/L() N	cu · , Di	NITE T &	-1-37	
	Registr	ar	AIG 2 4 2	UUD Miller de	1 19						

			_ Stete	Maryland / Dep	ertificate of De			711115	27732
			Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of De		Reg. No. 1	10.2000	3. Time of Death
	Physici		Stephen Lee Wise	Sr			Month E	Pay Year 2005	O + M
	/Medić Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Lo			c. County of Death	
			Union Memorial Hospital		Balti	imore		N/A	
	Funeral			. Age (In yrs. last birthday		Under 24 Hrs. 8 Hours Min.	. Date of Birth (Month, Day, Yea	9. Birth Cou	place (State or Foreign ntry)
	Director		215-78-6735 1 x 2 F Usual Residence of Decedent	45 Yrs.			DEC 24, 1	1959 Mar	yland
	/land		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary a-f sh	to	Maryland N/A		Baltimore	2			1 X Yes 2 ☐ No
	or 28	irec	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Cou	ntry?
	ath wi	Tail	3204 White Avenue		212			USA	
	er de	Funeral Director	V Armed For	dent Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ameri Black, White,	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28a-f show ent, it a Medical Ereching the notified at	by F	1 ♠ Never Married 2 ☐ Married 1 ☐ Yes . Give		1 ☐ Yes 2 X No S	Specify:		Specify:	White
9-0	72 hol	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupatio	on isa most of warking	16b.	Kind of Business/Ir	ndustry
21	ithin Ban	npie	Elementary/Secondary (0-12) College (1-	40(5+)	e kind of work done duri DO NOT use retired)	ng most or no rking	I.	Coofing,	Air Cond.
	iled w Hygier Iher tl		7 17. Father's Name (First, Middle, Last)	La	borer	3. Mother's Name (/		. — . — . — . — . — . — . — . — . — . —	ALL COIG.
Maryland	d be f antal i ted of	o Be	John Wise, Sr.		1.0		arye Shou		
ary.	shoul nd Me mark imark	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street and				o Code)
	alth a 27 is		Jerry L. Wise/brother		3204 White	Avenue !	altimore	. MD 2121	4
ore,	es 1 a of He filter		20a. Method of Disposition 1 ☐ Burial 24 ☐ Cremation 3 ☐ Removal from S	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Dat	e 20c.	Location - City or T	own, State
Ë	Pag Iment Iant: I		`4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre	ematory, In			altimore,	
Baltimore,	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28a-f show any njury or other traumatic event. It a Medical Exercitive transities to rediffed at once.		21. Signature of Funeral Service/Licensee		22 Name and Address of Cremation S 299 Frederic	ociety of ck Road	Marylan Baltimor	d, Inc.	28
			23a. Part1. Enter the disease, or complications that ce shock, or heart failure. List only one cause on ea	used the death. Do not en	nter the mode of dying, s	such as cardiac or r	espiratory arrest,	C, 11D 212	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	512 Syndr	ame				Onset and Death
	/Medical Examiner		resulting in death) Due to (c	r as a consequence of):					2 1
	ZXGIIIIICI	Ţ.	Sequentially list conditions, if any, leading to immediate	A Bacter	en, a				200th
(Ited Insit	Examiner	Cause (Disease or injury	zumonia					3 done
0,	an and rial-tra	Еха		or as a consequence of):					- 0-00
8760,	cate be executed physician and the burial-transit	dical	d						
9	entific ding p	/Mec	IF FEMALE:	Hi/					
Вох	The taw requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
P.O.	that the deathed by the atte	nysi	1 Yes 2 No 9 Unknown 9 Unknown						
	s that gned to	by P	Part II. Other significent conditions contributing to de	ath but not resulting in the	underlying cause given i	n Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ord	w requires t been signe should be	ted	Heretitis C, NOA, +	イン			1 🗌 Yes	2 □ No 3 □ Proi	pably 4 Minknown
Records,	e taw r has be je 2 sh	Completed					24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
E H	: The t						performed? 1 Yes 2 □ N		2 No
Vital	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 D No Hospital: 1 D No	05500	Othor	6. Place of Death (0			
of		J: To	27. Manner of Déath 28a. Date o	patient 2 ER/Outpatie	of 28c. Injury at		 5 ☐ Residence Describe how inj 	6 ☐Other (Special jury occurred	y)
ion	Attending r death. ector: After by the fune	atio	1 ☐Natural 5 ☐ Pending (Montr 2 ☐ Accident investigation	, Ďay Year) Injury	Work? M 1 ☐ Yes	2 □ No			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildin	of Injury - At home, farm, sig, etc. (Specify)	treet, factory, office	28f	Location (Street a	and Number or Run	al Route Number,
	oital o urs aft oral Di								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann	sis of examination and/or i	th occurred at the time, onvestigation, in my opinion	date and place, and on, death occurred	d due to the causer at the time, date a	(s) and manner as s nd place, and due t	tated. o the cause(s)
	To the To the comple	Σ	29b. Signature and title of certifier		29c. License nu	umber	29d. D	ate signed (Month,	Day, Year)
7				0	ATZ	43894		78, 18, 3	201
			30. Name and address of person who completed cause FELIPE WAYAS			1/ 1/2:	OVERAL		
	Sta	te			MEMOR!	14C F 101	PITAL		
	Registr	- 100	AUG 2.4 2005	gistrar's Signature	edi				

		-	For Stata Registrar	State of M	aryland / De	epartment Certificate			nd Menta		ne . No ² () ()	1.5_	27	133
	Physicia	an	1. Decedent's Name (First, Middle, I	ast)	1	wyne	ego	ar	Mo	te of Death onth gust		Year 2005	3. Time 6	
	/Medic Examin	er	4a. Facility Name (If not institution, g	nive street and number)				ocation of	City	/		of Death		
	Funeral Director		5. Social Security Number 6 219–44–7439	. Sex 7. Ag 1 □ M 2 □ F	ge (In yrs. last birtho 60 Yr	Months	1 Year Days	Hours	4 Hrs. 8. Da Min. (M	te of Birth onth, Day, Y LY 15,	1945	9. Birthpl Count	(rv)	or Foreign D.
	e Marylend la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD • N	I/A	10c. City, Town	BA	LTIM	ORE					- 21	City Limits s 2 ☐ No
	n with the	al Dire	10e. Street and Number 3704 CHESTLE PLA	CE		10f. Zip		224			. Citizen of W			
336	urs after deat al', or Items 2 Xurrana	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces	?	13. Was Deced If Yes, spec 1 ☐ Yes	ify Cubar	panic Orig , Mexican, Specity:	in? (Specify Y Puerto Rican,	es or No- , etc.)	14. Race Black Specify:	, White, e		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylend it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Madical Examination in Items i	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	()	Decedent's Usua Give kind of wor life. DO NOT us HC	rk done di	uring most	of working	16	b. Kind of Bus	siness/Ind		
Maryland 2	buld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, La EDGAR G. PHANEUE						r's Name (First		iden Sumame	a)		
	1 and 2 should be Health and Mental tem 27 Is marked other treumatic ev	,	19a. Informant's Name/Relationship NANCY GARNER/NII			Mailing Address BOX 1						_	Code)	
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery,	Disposition (Name crematory or of NFORES	ther place		Date 3/23/20		c. Location - 0	•		ND
Balti	permit. Pag Department Important: h any injury o		16	ans		6224 I	EASTE	RN AV	CHARL	LTIMOF	RE, MAR	& S YLAN	D 21	224
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	nty one cause on each	line.					piratory arres	t,	1	Approxim Interval B Onset and	etween
8760,	death certificate be executed e attending physician end id for use as the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	x sanguence of a consequence of s a consequence of s a consequence of	f):	ılar	· m	255				s we	reks
.O. Box 6	at the death certific by the attending patached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 Ectopic po					23d. Date Mon		ory Day	Year
S, P	uires that i signed by	by	Part II. Other significant condition	s contributing to death	but not resulting in	the underlying o	ause give	n in Part I.	2		cco use contri 2 □ No	ibute to th 3 ☐ Prob		of death? Unknown
of Vital Record	an: The law requires that the rificate has been signed by th tor, page 2 should be detache	Completed							_	4a. Was an autopsy performe	p p	rior to co	psy finding mpletion o	gs available f cause of
on of Vita	ding Physici h. After this cer funeral direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigs		jury 28b. Ti		28c. Injury Work	at Nu		5 🗌 Residen	ce 6 □Othe		y)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace of I	njury - At home, fan etc. (Specify)	m, street, factor	y, office			ocation (Stre City or Town,	et and Numbe State)	er or Rura	al Route N	umber.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 (Check only one)	Physician: To the bes xaminer: On the basis and manner:	A seriesales and				A - In A	Alternative and administrative and a second		and disp to	a the calle	B(S)
	With To T	Σ	29b. Signature and title of certifier	no Hone	death (Item 23a) (IOTH) Witter's Signature	29	C. License	ES-C	000	A	19UST	18 2	200 S	5
******	MV		30. Name and address of person was Jenny Hong	tho completed cause of	death (Item 23a) (Type, Print) VOIFE	Stre	et	Battin	rore l	Maryla	ind	2128	27
	St Regist	ate rar	31. Date filed (Month, Day, Year)	4 2005 32. Re	trar's Signature	Spark	0							

				State of Maryland / Department of Health and I 1- State Amend Item 24a per verb., G846-0846-051-beath	Mental Hyg	2005	27734
		9	-	Decedent's Name (First, Middle, Last)	2. Date of Deat	3	3. Time of Death
		Physici		MERVIN WALLACE AMREIN	Month	Day Ye	ar
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	August	15, 20 4c. County of D	
	1 .		si.	Upper Chesapeake Medical Center Bel Air		Harfo	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			Birthplace (State or Foreign Country)
10	ю	Director		213–16–9463 X *** 23 Yrs. 7	1/17/192	22 M	aryland
3		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1		Manyii f sho	ō	MD Harford Joppa			1127 Yes 2 □ No
0		death with the Maryland ms 23e or 28a-f show Fraust be notified at	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What	
0		3e or	<u>-</u>	1100 Hollingsworth Road 21085		USA	odiniy.
		72 hours after death w "netural", or Items 23e edical Examination	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - A	merican Indian,
	9	after or Ite		1 ☐ Never Married 27 Married 17 Yes 2 ☐ No	to Rican, etc.)		/hite, etc.
	5-0036	72 hours 'netural', dical Eva	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates WW II 1 ☐ Yes 2 ▼ No Specify:		Specify: W	nite
3	5-	"net	ete	15. Decedent's Education (Specify only highest grade completed) [Second of work done during most of work life. DO NOT use retired)	rking	16b. Kind of Busine	ss/Industry
8	2121	filed within Hygiene. othar then "	Completed	Elementary/Secondary (0-12) 12 College (1-4or 5+) Owner/Operator		General:	Stora
		filled Hygir othar	ပိ	-	ne (First, Middle, N		30010
12	Maryland	td be ental ked c	o B	- 1 - 1	ta Louise	,	
0	ary	shou ind M s mar umat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ıral Route Number,	City or Town, Stat	e, Zip Code)
15	Ž	alth a alth a 27 is		Louise I. Amrein/Wife 1100 Hollingsworth Roa			085
1	J. C.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "netural", or Items 23e or 28e4 show any injury or other traumatic event, the Medical Examinating the notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City	or Town, State
00	Ē	Page nent i			/2005	Street,	MD
	Baltimore	permit. Departr Importa any inji		21. Signature Funeral Service Licensee 22. Name and Address of Facility	_		
		90 5 5 9		Harkins Funeral Home, In			, PA 17314
				231 Part. Englished is ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac spock, of heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between
		Physician		Impediate Cause (Final disease or condition fesulting in death)			Onset and Death
		/Medical Examiner		Tesulting in death) Due to (or as a consequence of):			
3			<u>.</u>	Sequentially list conditions, b			
E.		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
05903		be executed sician and burial-transit	xar	that initiated events c			
0	760	bur bur	Ical E				
#	68	tificate by physical as the b	edic	0.			
	Вох	eath certific attending pl for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
	m	death e atte	icla	in the past 12 months? 1		Month	Day Year
	P.O.	by th	hys	9 ☐ Unknown			
2		res that the de signed by the a be detached to	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
3	ord	w require been si	pleted		1 🗆 Ye	s 2 1 √No 3□	Probably 4 Unknown
ervin	Records,	e faw r has be ge 2 sh	ple		24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
76		Th ate pag	Com		perform	ned? death	es 2□ No
	Vital	Physician: Th this certificate ral director, pag	Be	examiner?	th (Check only one	9)	
~	of	Q S. X	2		ome 5 Resider		pecify)
-		After une	lon	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how	w injury occurred	
es	isio	tten deat stor: / the	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined.	Opt Location (Cts	and and Alimbara	Rural Route Number,
mr	Division	P # ip =	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)	Hurai Houte Number,
-		urs urs aral		29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the car	use(s) and manner	as stated
1		the Ho hin 24 h tha Fu npletely	Medical	(Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, da	te and place, and o	ue to the cause(s)
		To the Hose within 24 ho To tha Funa completely f	ğ	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mo	onth, Day, Year)
	•			Dand 5 Du 03225.	5	AUR WET	17, 2005
-		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0	/
		10		24 Date Start March Court Vessel	or ma	2/0/9	/
		Sta Registr		31. Date filed (Month, Day, Year) AUG 2 5 2005 32. Registrar's Signature		,	
		, riegisti	21	AUG 2 5 2005 Proces St. Sports	25		

			1 - For State Registrar		State	e of Ma	arylan	d / Depa	artmen <i>rtificat</i>	t of H e of L	ealth a	and M	lental Hy	2ift f	5	27	73	5
	Discontinu		1. Decedent's Name (First	Middle, Las	t)								2. Date of De	ath			3. Time o	of Death
	Physic /Medi		ADA			CLARE			ARENS	ON			AUGUST	22	200		5:15	РМ
	Exami		4a. Facility Name (If not in	stitution, give	street and	d number)			4b. City,	Town, or	Location of	of Death			County of E		0.120	
			MILFORD MAN							LTIM				BA	LTIMO)RE		
	Funeral		5. Social Security Number	6. Se	x □M 2 X	7. Ag		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 106/12/	th W. Year)	9.	Birthpla Countr	ce (State	or Foreign
	Director		235-18-622 Usual Residence of Deced	4			92	Yrs.					067127	1913			W.V.	
	laryland show			County			10c. City	y, Town or Lo	cation							104	d. Inside C	City Limits
	Mary -1 sh	tor	MD	N/A			BAI .	TIMORE										2 No
	r 28a	rec	10e. Street and Number	.,,			DitL	TITIONE	10f. Zip	Code		-		10g. Citize	en of Wha	t Countr	v?	
	h wit	ai D	3606 MENLO	DRIVE						2121	5				U.S.	Α.	•	
	deat	by Funeral Director	11. Marital Status		12. Was I	Decedent I	Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	4. Race - A	merica	n Indian,	
9	or Ite	/Fu	1 Never Married 2	_	1 DY	d Forces? 'es 2 ☐ \ Give	10	- 1	1 □ Yes 2		Specify:	i, Pueno	rican, etc.)	1	Black, V	Vhite, et WHI7		
000	ural',	d b	3 X Widowed 4 □ Di		Year	or Dates:			103 /	2 KJ 140	эрвспу.				Specify:	MILL		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Everither most be notified at	Completed	15. De (Specify only	cedent's Ed highest gra	ucation de com <i>pl</i> et	ted)		(Give	dent's Usua kind of wor	rk done a	uring mos	t of work	ing	16b. Kind	d of Busine	ess/Indu	istry	
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	filed Hygie other	Ö	17. Father's Name (First, A					UL.	LIVIN		18 Mothe	r's Name	e (First, Middle,			luu	STURE	13
an	Mental Mental arkad o	To Be	MAX	,				FRIE	DMΔN			NCES		IMAIDON 3	umame)	STE		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Heath and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Exertiner must be notified at	F	19a. Informant's Name/Re	lationship (7	ype, Print)					(Street a			ai Route Numbe	er. City or	Town Stat			
ž	1 and 2 Health a iem 27 is		GILBERT H.	MILLE	R / N	NEPHE	W						TIMORE				,	
J.C.	of Herm Item		20a. Method of Disposition				20b. P	lace of Dispo	sition (Nan	ne of			Date		ation - City		n, State	
Ĕ	Page nent ant: If		1 🕅 Burial 2 □ Crem `4 □ Donation 5 □ O			rom State		-	FILOH			8/24	/2005	WOOD	LAWN,	ΜĎ	•	
3altimore,	permit. Pages Department of f Important: If Ite any injury or of		21. Signature of Funeral S	ervice Licen	600			22	. Name an	d Addres	s of Facilit	y SOL	LEVINS	SON &	BROS		INC.	
_	8 5 E 5 3		1 /as					8	900 RI	EIST	ERSTO	WN F	ROAD - I	PIKES				208
			23a. Part 1. Enter the offer shock, or beart failure	ase, or comp b. List only o	lications th	nat caused on each lig	the death	n. Do not ent	er the mode	e of dying	, such as	cardiac o	or respiratory a	rrest,	10	II	Approximat nterval Bet	te tween
	Physician		Immediate Cadse (Final disease or condition	0.004	a. /	71he	ore !	scles	which	- (s.d.	ion	scula	- 1	1) () (3	Onset and	Death
	/Medical Examiner		resulting in feath)		Due	to (or as	a consequ	uence of):										
		10	Sequentially list conditions		b	to (or as	CODE POLICE	ience of):										
	ted nsit	nin	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	` ≺	546	10 (01 23 1	a consequ	derice or j.										
	al-tra	Examiner	that initiated events resulting in death) Last	- 1	c Due	to (or as a	a consequ	uence of):								-		
8760,	cate be executed obysician and the burial-transit	dicai		·	d													
9	ifficat g phy as the	0 1			·													
Вох	eath certific attending p	In/N	IF FEMALE: 23b. Was decedent pregna	int		, outcome ve birth)c .					23	d. Date of	delivery		
	deat e att	sicie	in the past 12 months 1 ☐ Yes 2 ☑ No	?	4□Pr	regnant at			Ectopic pre Other (spe						Month	D	ay '	Year
P.0	at the de by the a stached	Physician/M	9 Unknown															
	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant c	onditions co	ntributing t	to death bu	it not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use	contribute	e to the	cause of c	leath?
oro	v require been sig should t	ted											101	′es 2□	No 3□	Probab	ly 4 🖽	Jnknown
Records,	e taw has b	Completed											24a. Was		24b. Were	autops	y findings pletion of c	available ause of
E		Cor												rmed? 2 No	death 1 🔲 Y		□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to n examiner?	-	Hospital: .							•	(Check only o					
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on	ding th. Th.: After funer	tion	1 Natural 5 □	Pending nvestigation	(A	Month, Day	Year)	Injury	M	Bc. Injury Work	?` es 2 □ N		od. Describe is	iow injury (occurred			
Division	I or Attending after death. Director: After	ifica	3 ☐ Suicide 6 ☐	Could not be	28e. Pl	lace of Inju	ry - At ho	me, farm, stre					28f. Location (S	treet and I	Number or	Rural F	Route Num	ıber.
Ö	al or A s after al Direct	Certification:	4 Homicide		bı	uilding, etc	. (Specify	")					City or Ton	m, State)				
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E		29a. Certifier 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rtifying Phy	sician: To	the best o	f my knov	wledge, death	occurred a	it the time	e, date and	d place, a	and due to the o	cause(s) ar	nd manner	as state	ed.	
	the H nin 24 the F nplete	Medical		2	and n	nanner sta	ted.	on and/or inv	estigation,	in my opi	nion, deat	h occurre	ed at the time, o	date and pi	lace, and c	lue to th	ie cause(s)
	S S S S	-	29b. Signature and title of	ertifier	×2		1		29c.	License	number		1	29d. Date :				
,	179		· U DE	4	2/	1	_			DI	58	12		Huyi	ud:	23	200	/)
	12		30. Name and address of p	erson who c	ompleted o	ause of de	ath (Item	23a) (Type, I	-	+	2	// 3	36					
	Sta	te	31. Date filed (Month, Day,	Year)		2. Registra							<i></i>					
	Registr	ar	AUG 2	5 2005	196	00,42.0	1.	Aces										

State of Maryland / Department of Health and Mental Hyging 05 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Therese Marie Braddock 20, 2005 7:50 p^M Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Martin's Home Catonsville
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Baltimore 8. Date of Birth (Month, Day, Year)
Sep. 14, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F 283-54-3042 Yrs. 85 Director 1919 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc should be filed within 72 hours atterned Mental Hygiene. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles L. Braddock Stella Rose King permit. Pages 1 and 2 shoul Department of Health and Me Important: If Item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Sr. Gerard O'Connor / Supervisor 601 Maiden Choice Lane, Catonsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Bunal 2 Cremation 3 Removal from State 5 Other (Specify) New Cathedral Cem. Donation 8/24/05 Baltimore, Maryland ol Fuperal Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final NE **Physician** U MONI disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner The law requires that the death certificate be executed use as the burial-transit msigned by the attending physician and resulting in death) Last Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2-1 No 1 Yes 3 Probably 4 □Unknown Completed been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate 1 Yes 2 1 No 2 \(\text{No} the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 ER/Outpatient 3□ DOA Certification: To I Diractor: Atter this d in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No death 2 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, BALTIMORE, MD 21229 3455 WILKENS SAMBANDAM 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 25

2005

State of Maryland / Department of Health and Mental Hygiepen 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Month Year Elizabeth Ann Blanchette 20, 2005 12:40 AM /Medical Aug. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Ctr. Towson Baltimore Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2X F Director Yrs. 212-28-6694 74 19,1930 Maryland Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Erand of mast be notified at Director 1 TYes 21 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1724 Kirkland Road 21222 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. Noonan Marie Koester 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If itam 27 is
any injury or other trau Mr. Leonard J. Blanchette, Sr. 1724 Kirkland Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 1 4 □ Donation Hølly Hill Mem. Gdns. 8/23/2005 Middle River, MD 21. Signature of Figureral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122 21222 P.m. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician PERITONEAL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicef Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and (itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)47721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

Baltimore, Maryland 21215-0036

Records, P.O.

Division of Vital

		1 - State Registrar		nd / Department of I Certificate of	Dealli	Re	g. No.	0	27738
Physic	ian	1. Decedent's Name (First, Middle, L	Í			2. Date of Death Month	Day	Year	3. Time of Death 0203 A
/Medi Examir		Baby Girl Bu 4a. Facility Name (If not institution, gi		4h City Town	or Location of Death	July		2005	0203A
Exami	ier		Bayview Medi			City	4c. County	or Death	
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Fore
Director		HOHE	1□M 2√2F	Yrs. Months Days	Hours Min.	(Month, Day, July 2,		Cou	vland
pur *		Usual Residence of Decedent 10a. State 10b. County	100 Ci	ty, Town or Location					
iled within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Itams 23a or 28a-f ehow int, the Madical Examiner must be notified at	5								10d. Inside City Lim
28a-1	Funeral Director	DC 10e. Street and Number		ashington					1 □ Yes 2↓□
23a or	٥	104 Danvury Stre	a t	10f. Zip Code	00000	10	g. Citizen of t		ntry?
TIS 2:	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was Decedent of H	20032	rify Yes or No.		SA America	can Indian,
or Ita	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. Was Decedent of H		lican, etc.)		ck, White,	
E. E.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify	bla	ıck
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a Mer narke	T _o				Ebony Bu				
h and 7 Is n		19a. Informant's Name/Relationship		19b. Mailing Address (Street					Code)
item 27 other tra		Bayview Medical 20a. Method of Disposition		4940 Eastern Place of Disposition (Name of					
3 5 5 5		1 Burial 2 Cremation 3	Removal from State	emetery, crematory or other place	ce) Da	16 20	Oc. Location -	City or To	own, State
Department Important: In any injury o		'4 □ Donation 5 ☑ Other (Special							
Deport Import any inj		21. Signature of Funeral Service Uice Ronald	Wade / Director	22. Name and Addre	ss of Facility Omy Board	655 W. E	Baltimo	re S	treet
-		220 Cost Seter the disease trace	1 / XX	Baltimore.	MD = 21201				
		23a. Pan I. Enter the disease, or conshort, or heart failure. List only		1					Approximate Interval Between Onset and Death
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s been signed to should be deta	y P	Part II. Other significant conditions			en in Part I.	23e. Did toba	cco use contr	ibute to th	e cause of death?
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s cer direct	OB	examiner? 1 ☐ Yes 2 ₩ No	Hospital: 1 X Inpatient 2 -	ER/Outpatient 3 □ DOA Othe	26. Place of Death (- 0.000	(0)	
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	P 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury	4 Iduising Home	d. Describe how)
death. ctor: After / the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio			(? Yes 2 □ No		,		
ecto by th	Certification:	3 Suicide 6 Could not b	286. Place of injury - At no	me, farm, street, factory, office	28	f. Location (Stree	et and Numbe	or or Rural	Route Number.
od in	Sert	4 - Hornicide	building, etc. (Specify	")		City or Town, S	State)		
within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death occurred at the time	ie, date and place, and	d due to the caus	se(s) and mar	ner as sta	nted.
n 24 or Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of examinal and manner stated.	ion and/or investigation, in my op	pinion, death occurred	at the time, date	and place, a	nd due to	the cause(s)
Totl		29b. Signature and title of certifier	910	29c. License	number	29d.	Date signed	(Month, D	Day, Year)
		N. Churty	her Talder a	DO0	56568	J.	uly 2	2	005
	1	30. Name and address of person who	completed cause of death (to-	20-1 /T D: 11				7.000	
		W. Christopher G	olden 600 N	orth Wolfe Stre	et Baltin	none Ma	ry lanc	121	287
		31. Date filed (Month, Day, Year)	32. Segistrar's Signat	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 3,23e per doc 3847 9-2-05 vt
State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 23a pt.II per phy 6846 8-25-05 tas
Registrar Registrar Registrar Registrar 27739 Reg. No 2. Date of Death 20 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 20A ARRON 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 3634 Thoenix

If Under 1 Year | If Under 24 Hrs. 10 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foleign Country) **Funeral** 1 M 200 F Months Days Hours Min 360-750 Yrs. Director Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-1 ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director DALTIMOR 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Itams 23a or 36 lai 0 0 i filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Maritaf Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) onemaker non or other traumatic event, permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Itam 27 Is marked other any injury or other traumatic avent. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be raneu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, \$tate, Zip Code) Moerux Me 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date. 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) onetel 22. Name and Address of 21. Signature of Funeral Service Ligenses 20 Timonium MD21093 SFUNERAC+ CRONATION CENTE 10 PUATIVE PEACEFUL ALTE ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. 23a. Part1. Enter the disease, or complications, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last G Due to (or as a consequence of): Examiner this certificate has been signed by the attending physicien and al director, page 2 should be detached for use as the burial-transit Due to (s a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertorm 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 140 CHIL 32. Registrar's Signatu Zar)5 2005

DHMH 17 Rev 1/2001

State

Registrar

A SP S

			1- For State of Maryland / Department of Health and Mental Hygier 005 27740 Certificate of Death Reg. No. 005
_	Physic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year August 24 2005 3. Time of Death Month Day Year 1:21 9 M
	/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral		BALTIMOLE WASHINGTON MEDICAL CENTER GLEN DURJIE ANDE HRUNDEL 5. Social Security Number 216 20 5226 Security Number 7. Age (In yrs. last birthday) 10 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 28, 1926 Months Days Hours Min. Oct. 28, 1926 Maryland
	Director		216 20 5226 103 M 2 F 78 Yrs. Months Days Hours Min. Oct. 28, 1926 Maryland
4	death with the Maryland ms 23a or 28a-f show II sist be notithed at	5	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 □ Yes 2 ☒ No
I	ith the Ma or 28a-f	Director	Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
osef	ath with	ral D	313 Hospital Drive 21061 U.S.
107	after or Its	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ XWidowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No Specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or Noll of H
SP	in 72 hours in 72 hours n"natural;	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
- 9	d 212 filed with Hygiene. Hygiene.	Com	Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker U.S. Post Office
BRANDEN BURG	Maryland 212: nd 2 should be filed within th and Mental Hygiene. 27 Is merked other than traumatic avent, the M	To Be	17. Father's Name (First, Middle, Last) Lawrence Brandenburg 18. Mother's Name (First, Middle, Maiden Sumame) Mary Reese
(2)	Maryla 12 should h and Men 7 Is marka rraumatic	[19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zip Code) 2207 Shetland Way Bel Air, Maryland 21015
3Oc	or Health		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
RAL	Baltimore, bernit. Pages 1 a bepartment of Hee mportant: If item in the injury or other once.		'4 Donation 5 Other (Specify) Glen Haven Mem. Park 8/26/2005 Glen Burnie, Maryland
b	Baltimo permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23. Part Filter the disease and molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
	Physician		23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death ACL - FCEM (4)
	/Medical Examiner		Me hat Heart Failer
	√ pe isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Diseas
	8760, \$ sate be executed physician and the burial-transit.">\$ sate be executed and the burial-transit.		that initiated events resulting in death) Last Due to (or as a consequence of): Die to (or as a consequence of): Die to (or as a consequence of): Many Year 1
	10 - 40	ledical	d. provide (1)
	Records, P.O. Box 68 The law requires that the death certifice te has been signed by the attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 1 No 9 Unknown 23d. Date of delivery 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year
	rds, P.O. I quires that the de n signed by the a	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Probably 1 Yes 2 No 3 Probably 2 Yes 2 No 3 Probably 3 Yes 2 No 3 Probably 4 Yes 2 No 3 Probably 4 Yes 2 No 3 Probably 4 Yes 2 No 3 Probably 4 Yes 2 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Probably 4 Yes 3 No 3 Yes 3 Ye
		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
	f Vital Rysician: The is certificate his director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 10 6
	on of oding Phy th. : After this of funeral d	I	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending investigation
	Oivisi or Attar after dea Diractor in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Division of Vital To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifical completely filled in by the funeral director,	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nyanher stated.
	To the within To the comple	Me	29b. Signature and titler of certifier: 29c. License number 29d. Date signed (Month, Day, Year)
	BYI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
		ate	Elliaff Gorbary und 1411 Madison lak Urive Glen During und, 2106, 31. Date filed (Month, Day, Year) 32. Begistrar's Signature
	Regist		AUG 2 5 2005 Brane B. Brane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 Physician Bush The 1 ma Μ. August 20 6:39 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore Harbor Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec. 22, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. Months Days Hours 1 M 2 F England 231 05 8517 Director 85 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with till Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural", or items 23a or 2 amy injury or other treumatic event, the Madical Examiner must be not once. 3723 St. Margaret Street 21225 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced 16b. Kind of Business/Industry 15 Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gwendolyn Sewell Kristoffer Braaten ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Rink / Daughter 3723 St. Margaret Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 8/24/2005 ⁴ 4 □ Donation 5 Other (Specify) Lorraine Park 21. Sign way of F neral Service Lic 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VENTRICULAR /Medical Due to (or as a consequence of) **Examiner** LABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The taw requires that the death certificate be executed attending physician and for use as the burial-transit YPERTENSION Due to (of as a consequence of): Box 68760. REGURGITATION Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this After thi 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Dire 4 Momicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AUGUST 587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJID S. HANOVER ST., BALTIMORE, MD 21225 100 egistrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

AUG 2 5 2005

bares

ADH
CARLTON CRAWFORD
05-5662

)00	2		For State Røgistrar	State of Maryland / Depa	irtment of Health and f <i>tificate of Death</i>		2005	27742
	Physici:		1. Decedent's Name (First, Middle, Last,	Crawford		2. Date of Death Month AUGUST	Day 2005	3. Time of Death 1159 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give 3700 GREENSPRING		4b. City, Town, or Location of Death BALTIMORE CITY	1	4c. County of Dea	
	Funeral Director	<	5. Social Security Number 6. Sec. 230-22-9302		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, N	10 / 2 Bir 1922	thplace (State or Foreign ountry)
	within 72 hours after death with the Maryland ene. then "nature!; or items 23a or 28a-1 ehow he Madigal Examinar must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Nary and 10e. Street and Number	10c. City, Town or Lor Balt	cation MOTE 10f. Zip Code		Citizen of What Co	10d. Inside City Limits 1 to Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "naturel; or items 23a or 28a-1 show apply injury or other traumatic event, the Mudical Examination must be notified at another.	Funeral Director	3700 Green 11. Marital Status	SPring Ave. 12. Was Decedent Ever in U.S. Armed Forces?	2/2/1 Was Decedent of Hispanic Origin? (Silves, specify Cuban, Mexican, Puert		14. Race - Ame Black, Whit	erican Indian,
-0036	2 hours after ature!, or its	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu	1 Yes 2 No If Yes, Give Year or Dates: cation 16a. Deced	☐ Yes 2 No Specify:	16	Specify: B	lack
121215-0036	filed within 7; Hygiene. other then "n	Completed	(Specify only highest grad	College (1-4or 5+)	kind of work done during most of wor DO NOT use retired)		NA	
Maryland	uld be fi Mental H rrked ot rtic ever	To Be	17. Father's Name (First, Middle, Last)		tusk.	ne (First, Middle, Ma	liden Sumame)	unt
	and 2 should lealth and Men m 27 ie marke her traumatic	Marine Marine	19a. Informant's Name/Relationship (7) MS. Maureen	po, Print) (caretaker) 19b. Mailin Shanklin 3/13 20b. Placo of Dispo:	g Address (Street and Number or Ru	Ive. Pal	to, Md.	21244
Baltimore,	artment of Parament of Paramet: If ite		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	temoval from State Cometery, crem Mt. Z	natory or other place)	2005	ansda	wne, Md.
Ba	permit. Departimont import eny inj) Joseph of	L. Kuss 22	seph L. Kuss 122 W. North A.	Funeral Je Balto), Ma. 21	216
}	Physician /Medical		23a. Part I. Enter the disease, or compl styck, or heardfailure. List only of Immediate Cause (Final disease or condition resulting in death)		er the mode of dying, such as cardiac	4	t,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	Due to (or as a consequence of):				
*	and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
68760,	tificate be executed g physicien and as the burial-transit	edical E	Į.	1.				
P.O. Box	Physician: The law requires that the death cert this certificate has been signed by the ettending till director, page 2 should be detached for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy		23d. Date of de Month	livery Day Year
ords, P	equires that en signed b ould be deta		Part II. Other significant conditions co	ntributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba 1 □ Yes	0-4	o the cause of death? robably 4 Dunknown
Division of Vital Records,	n: The law r licate has be r. page 2 sh	Completed			177-16700	24a. Was an autopsy performs	prior to death?	utopsy findings available completion of cause of
Ţ	ysicial nis certii I directo	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	th <i>Check only</i> one) ome 5 Residen		city) SCENE
sion o	Attending PI ir death. ector: After ti by the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury Pour Month, Day Year) 28b. Time of Injury 1005 1005 1000	28c. Injury at Work? 1 □ Yes 2 No	news injury	injury occurred as	
DİX	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		Baltimale	1 (M)	reenspring live.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
)	Vije To	-	29b. Signature and title of certifier	Horel MA	29c. License number OCME		I. Date signed (Mont JGUST 22 ,	2005
	/		Pamela E. South	mpleted cause of death (Item 23a) (Type, I	PENN STREET, BALT	IMORE, MAI	RYLAND. 21	.201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registar's Signature	frak.			

State of Maryland / Department of Health and Mental Hygieren 05

			1 - For State Registrar	Otato or int	arytaria / t	Cei	rtificate of	Death	i intorna, tri	Reg. No		21145
			Decedent's Name (First, Middle, La	st)					2. Date of D	eath		3. Time of Death
	Physici: /Medic		Eleanor A.	Crunklet	on				Month August	16.	,	12:20 P ^M
	Examin		4a. Facility Name (If not institution, giv		<u></u>		4b. City, Town, o	r Location of De			c. County of Dea	
			Holy Cross Hospit	tal			Silver S	pring		М	lontgome	rv
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last bii	thday)	If Under 1 Year Months Days	If Under 24 H		irth	9 Bir	thplace (State or Foreign ountry)
	Director		211-16-6126	1□ M 2Ã F	80	Yrs.	World S Days	Tiodis IVII	May 1	0, 19	925 Per	nnsylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	partica					10d. Inside City Limits
	anyla shov	-										1 ☐ Yes 2 🛣 No
	8e-1	Director	Maryland Montgom	nery	Silver	Spr	T			10 5		
	with the or 2 ten		10e. Street and Number				10f. Zip Code				itizen of What C	ountry?
	ath v	rai	2044 Middlebridg	T		140.1	20906		10		S.A.	
	itam itam	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces?	ever in U.S.	13. \	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	0-	14. Race - Ame Black, Whi	
2	Irs aft	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	•0	'	1 ☐ Yes 2 🔀 No	Specify:			Specify:	Vhite
5	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiens. f Health and Mental Hygiens other treumatic event, the Medical Examiner must be notified at		15. Decedent's E	ducation	16a	. Deced	dent's Usual Occup	ation		16b. F	Kind of Business	
2	nin 7. nin nin	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	<u></u>	(Give life. L	kind of work done on DO NOT use retired	during most of w d)	vorking			
-	d with	E O	12	College (1-401 c	177	В	uyer			Dep	artment	Store
2	othe othe	Bec	17. Father's Name (First, Middle, Last,)				18. Mother's N	ame (First, Middle	e, Maider	n Sumame)	
<u> </u>	uld b Venta irked itic e	To E	Odesef Pappas					Pene]	Lope Nika	as		
<u>8</u>	and Name		19a. Informant's Name/Relationship (ng Address (Street					
Σ.	and 2		Pennelope Crunkl	eton (Daug	hter) 2	044	Middleb	ridge Dr	., Silve	er Sp	oring, N	D 20906
ב	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tree		20a. Method of Disposition	Tomoval from State	20b. Place o cemete	f Dispo	sition (Name of matory or other place	(e)	Date	20c. L	ocation - City or	Town, State
Ĕ	Page nent int: If		'4 □ Donation 5 □ Other (Specif		Fernw	ood	Cemeter	y 8/	/22/05	Fe	ernwood,	, PA
Daltillior	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	7600	#CC93	21,22	Name and Addre	ss of Facility	Δ			
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П			23a. Part1. Enter the disease, or com shock, or heartradure. List only	plications that caused one cause on each lin	the death. Do	not ent	er the mode of dyin	g, such as cardi	iac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Sepsis								Onset and Death
	/Medical		resulting in death)	w	a consequence	of):						l day
	Examiner		O and a little line and distance	b. Renal F	ailure							1 day
,	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):						
	ecuter nd trans	Examiner	that initiated events	c. Hyperna								1 day
5	e exe		resulting in death) Last	Due to (or as	a consequence	of):						
00/00	ate b hysic the bi	Medicai	•	d								
Ď	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Mec	IF FEMALE:									
ה מ	uires that the death cer signed by the attendin d be detached for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal death		Ectopic pregnancy	,			23d. Date of de Month	livery Day Year
	se de the a hed f	Physician	1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5∟	Other (specify)					,
Ċ	hat the deby detac	Ph	Part II. Other significant conditions of	contributing to death b	ut not resulting i	n the ur	nderlying cause giv	en in Part I	23e. Did	tobacco	use contribute t	o the cause of death?
Ž.	ires t signe	l by		, , , , , , , , , , , , , , , , , , ,	or the total and		noonying occoorgiv	OII II I W. I I		Yes 2		robably 4 XUnknown
corus,	w require	Completed							-			
5	e law has t	npi							24a. Was		24b. Were an prior to death?	utopsy findings available completion of cause of
<u> </u>	cate cate								1 ☐ Yes	2 X No	1 ☐ Yes	2 □ No
<u>ק</u>	Physiclen: this certificantal director.	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0.5	eath (Check only			
5	Phys this al dir	To	1 ☐ Yes 2 💢 No 27. Manner of Death	1 KJ Inpatie		tpatien Time of	I 3LI DOA	4 LI Nursing	Home 5 ☐ Res			ocity)
	ling After funer	ion	1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year)	Injury	Wor	k? Yes 2 □ No	280. 0030100	now inju	Ty occurred	
2	tend death stor: , the	ical	2 Accident investigatio 3 Suicide 6 Could not b	OB Place of Init	uny - At home fa	arm sto	eet, factory, office	703 2 100	28f Location	(Street a	nd Number or R	ural Route Number,
	or A after Direction by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	arri, 3(1)	eet, lactory, office		City or To	wn, State	в)	arar route reamber,
	spitel ours nerei filled		29a. Certifier 1 Certifying Ph	nysician: To the best	of my knowledge	e. death	occurred at the tin	ne, date and pla	ce, and due to the	cause(s	and manner a	s stated
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2.	edicai		miner: On the basis of and manner sta	examination ar							
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Mont	th, Day, Year)
			A.NO	waz.			D50	1890	-	8	5-16-	05
	ħ		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Туре,	Print) GAR					
	()		AHMED NAWA	2 PO BO	0x 83	810	2 GAIT	HER	SBURG	7 4	no 20	0883.
	Sta		31. Date filed (Month, Day, Year)	32. Ragistra	ar's Signature	M	gover!					
	Registr	ar	AUG 2 5	TAAA	Construct 10	9	·					

29d. Date signed (Month, Day, Year)

/N Ex		edi ni	
un ire			
MO	H	ic.	

or Items 23a or 28a-f sharing must be notified.

8/20/05

as the burial-transit 68760, the attending physician Box (P.O. Division of Vital Records, this

Baltimore, Maryland 21215-0036 and Mental Hygiene. should be fi and Mental H permit. Pages 1 and 2 Department of Health a Important: If item 27 la any injury or other trae Physician /Medical Examiner Examine Physician/Medical þ Completed e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygies 05 1 - For Stete Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death LILLIAN H. CHABINAK AUGUST 20, 2005 10:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death PICKERSGILL RET. COMMUNITY TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5/19/1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 21 F Yrs. 87 MARYLAND 219-05-9609 Usual Residence of Decedent 10a State 10c, City, Town or Location 10h County 10d. Inside City Limits 1 TYes 2 TWo BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8307 PLEASANT PLAINS ROAD 21286 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗓 No Specify: Specify: 3 XWidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE COUNTY BOARD Elementary/Secondary (0-12) College (1-4or 5+) OF EDUCATION **6YEARS** PRINCIPAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOMER M. HUTCHISON DINA ASCHE 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSANNA CHABINAK-UHLIG/DAUG. CHAPEL HILL, NC 27514-1502 112 ESSEX DRIVE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 8/23/2005 CATONSVILLE, MD ` 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signa ut of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction Myocardial minutes Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Urmentia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

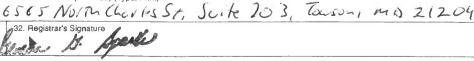
1 ☐ Yes 2 ☑ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗷 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

31. Date filed (Month, Day, Year) AUG 2 5 2005

Jason Blackmo

(Check only one)



mo

DHMH 17 Rev 1/200

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061199

State of Maryland / Department of Health and Mental Hygie 2005 2774

			1 - Stata Registrar		Cei	rtificate of	Death	Re	g. No.	21143
	Physici	an	Decedent's Name (First, Middle, Last) DALICESC)				2. Date of Death Month	Day Yea	
	/Media	al	FRANK J. DAUSES			41. 03. T		AUGUST	22, 2005	11:40 A ^M
-	Examir	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of De	
			CHARLOTTE HALL VE' 5. Social Security Number 6. Se		n yrs. last birthday)	COMPTON If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	ST. MAI	
	Funeral Director			3-M 2□F	Yrs. ast bittiday)	Months Days	Hours Min.	Month, Day, 5/21/19		Birthplace (State or Foreign Country) ARYLAND
	and w		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	MD Anne Ar	undel	Glen Bu	ırnie				1 □ Yes 2 □ No
	the the 288-	ect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	with Se or	ā	304 MONTFIELD LAND	-		21061			USA	
	Jeeth	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.		dispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No-		nerican Indian,
215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "naturel", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or DateKOF		If Yes, specify Cubi 1 ☐ Yes 2 🂢 No	an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	hite, etc. HTTE
ş	2 hot	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	
2	7 nin 7. Mad Mad	Completed	(Specify only highest grad	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ng		,
	filed with Hygiene. Ither ther	EO.	8TH GRADE	College (1-401 5+)	MAIN	VTENANCE			BROADMEAL)
Maryland 21	~ - 0 2	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	faiden Sumame)	
<u>a</u>		To E	FRANK DAUSES				MARIE U	NAVAILAE	BLE	
<u>8</u>		_	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State	, Zip Code)
Σ	1 and 2 Health a tem 27 Is		MICHELLE D. KRAMER	R/DAUGHTER	304 N	MONTFIELD	LANE GL	EN BURNI	E MD 2	1061
ē,	ges 1 ar t of Hea tf Item 3 or other		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Name of	ce)	Date 2	Oc. Location - City	or Town, State
Ē	Pages nent of int: If It		1 🛣 Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)	removal morn state	LAKEVIEW			/2005	SYKESVILI	.E. MD
saltimore,			21. Signature of Funeral Service Licens							HOME, P.A.
ñ	permit. Departr Importe eny Inj		Leutha NY	they -			RAVEN BL		SON, MD	21286
	*		23a. Part1. Enter the disease, or compl	ications that caused the						Approximate
			shock, or heart failure. List only of immediate Cause (Final	ne cause pn each line.	I. à.					Interval Between Onset and Death
	Pnysician /Medical	ľ.	disease or condition resulting in death)	a T/YP	4 1/2/10-)				
	Examiner			Peci	onsequence or):	lucer 1	- 1000	,		
		<u></u>	Sequentially list conditions,	Due to (or as a re	onsequence off:	V4)(~(1	am	1		
	ted	Examiner	Sequentially list conditions, I any, basing to immediate cause. Enter Underlying Cause (Disease or injury	Alah	Pale 198	1	r disis			1
	and and	хаг	that initiated events resulting in death) Last	Due to (or as a c		aj				
3	icate be executed physician and s the burial-transit									
09/89	phys phys the	Medicai		d						
_	E 0 6		IF FEMALE:	23c. If yes, outcome of	pregnancy				22d Date of a	to live and
o n	eath ce attendii for use	Physician/	in the past 12 months?	1□Live birth 2 [4□Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	Day Year
j	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ie or death 3L					
ב.	res that the de signed by the a be detached f	P.	Part II. Pher significant conditions co	ntributing to death but n	not resulting in the u	nderiving cause giv	en in Part I	23e. Did tob	acco use contribute	to the cause of death?
က်	signe signe d be	by	Vactor 1 100	cir Hu	RIMING	en i in				Probably 4 Dinknown
Ö	w require been signshould is	etec	11-10		1-11 gi /a	<u> </u>				
ည္	ataw as b e 2 s	Completed						24a. Was ar autopsy	prior to	autopsy findings available o completion of cause of
=		Co	_					perform 1 ☐ Yes 2	ed? death' □No 1 □ Ye	
Vital Records,	vysicien: Th	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	
0	Physic this c	2	1 □ Yes 2 No	lospital: 1 Inpatient	2 ER/Outpatien		1 Nursing Ho.	me 5□ Resider	nce 6 Other (Sp	pecify)
	ng Ph fter th	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	f 28c. Injur War	y at k?	28d. Describe ho	w injury occurred	
000	Vitendi death. ctor: A y the fu	ati	2 ☐ Accident investigation				Yes 2 □ No			
DIVISION	or Attending P after death. I Dirsctor: After t d in by the funera	ΪĮ	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (At home, farm, str Specify) 	eet, factory, office		28f. Location (Str City or Town,	eet and Number or . State)	Rural Route Number,
	itel o irs aft el Di led in	Certification:								
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best of n nar: On the basis of ex and manner stated	amination and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To th Withir To th Yomp	Me	29b. Signature and title of certifier	10		29c. Licens	e number	29	d. Date signed (Mo.	nth, Day, Year)
	1			V 1		D	006194	7	8/22/	05
ì	11/		30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type	Print)	000111	1		/
1	1		MANOJ MATHUR, MD		LOTTE HAL		HARLOTTE	HALL, MD	20627	
	Sta	te	31. Date filed (Month, Day, Year)	32. Hegistrar's		·				
	Registr		AUG 2 5 20	05 1	. 11. De	rever!				

State of Maryland / Department of Health and Mental Hygie 2e0 05 27746 1- State Registrar AMEND ITEM #10a-f PER INF G8465tiffqaste/05Departh . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day_ AUGUST 2005 11:47AM Donald Smink Diffenderffer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 2□F Months Director 216-38-4822 63 Oct. MD Usual Residence of Decedent death with the Maryland 10a, State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Madical Examiner must be notified at FL. MARTIN Director 1 ☐ Yes 2 No MD **Baltimore** JENSEN BEACH Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 631 NW Broken Oak Trail ō 1900 Ridge or Items 23e 21136 34957 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s filed within 72 hours after de I Hygiene. other then "naturel", or Item 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Nationwide Pest & Elementary/Secondary (0-12) College (1-4or 5+) Termite Control 12 n/a Owner Pages 1 and 2 should be filed venent of Health and Mental Hygies ont: If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Ross Diffenderffer Elizabeth Smink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tre once. Elisabeth Diffenderffer/wife 1900 Ridge Rd., Reisterstown, MD 21136 20b. Place of Disposition (Name of cametery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Comfort Crematory 8/25/05 Alexandria, VA 21. Signature of Euneral S ²², Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 ervice Licensee Inc. Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PULMONARY EDEMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MITRAL STENOSIS Sequentially list conditions, any labeling to initial actions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner rsician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Yes Records, P.O. 9 Unknown 9 Unknown signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACUTE RENAL FAILURE 3 Probably 4 □Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page Division of Vital 1 Yes 1 🗌 Yas Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inhoatient 2 PR/Outpatient 3□ DOA this 28a. Dale of Injury (Month, Day 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08-23-05 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON , MARYLAND 21204 FRANCIS KHOO M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 05 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician Addiebelle B. Dauber 23, August 2005 12:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1202 Athens Court Bel Harford County If Under 1 Year Months Days If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 C F Yrs 218-01-6870 85 Director Sept.24,1919 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to I feem 27 is marked other than "natural", or I tems 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Evantrar must be notified at 1 ☐ Yes 2(XNo Directo Maryland Harford County Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1202 Athens Court 21014 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Town Plaza Apts. 12 N/A Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis C. Maisel Addiebelle White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Deaton (Daughter) 1202 Athens Court Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 Burial 2 X Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. Evans Funeral Chapel 8 23-05 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Peaceful Alternatives Funeral&Cremation Ctr.,P.A 21. Signature of Funeral Service Licenses 2325 York Road Timonium, Maryland 21093 1. Inter the disease, or complications k, or heart failure. List only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death iate Cause (Final enew **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy φ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 2[No 1 Yes 2, 100 1 Yes After this certifice funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Certification: To 2 No 1 Inpatient 2 | FR/Outpatient 3□ DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours after death.

To the Funerel Director: Al
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check ont 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certific 29c. License number and address operson who impleted cause of death (Item 23a) (Type, Print) 30. Na 11 MACDIA 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 2005 Registrar

Funeral Director

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar				Certificate	of L	Death		R	eg. No.			, ,	
		1. Decedent's Name (First, Midd	lie, Last)						2. Date of Death Month Day Year				3. Time of Death		
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/Medic		4a. Facility Name (If not institution	Denney			4b. City. T	Town, or	Localion	of Death	1148456		4c. County of Death		0.10 11	
Examin	ier	251 Owensville	- 01	,				iver					e Aru	ınde1	
		5. Social Security Number						If Under	24 Hrs.	8. Date of Birth		7111110		lace (State or Foreign	
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MO TH		10a. State 10b. Count	/	10c. Ci	ty, Town o	or Location							10	0d. Inside City Limits	
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28a-	Director	10e. Street and Number 10f. Zip Code								1	0a. Citi	zen of W	hal Coun	try?	
10 8		251 Owensvill		20778					U.S		,.				
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tem I	nu	11. Marital Status	Armed I	cedent Ever in U Forces? : 2 □ No	,	If Yes, speci	fy Cuba	n, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)			k, While,		
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tura			15. Decedent's Education			ecedent's Usual	l Occup:	ation			16h Ki	Kind of Business/Industry			
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ther and	ပိ	17. Father's Name (First, Middle	1 220			18. Mothe	er's Name	e (First, Middle, i	(First, Middle, Maiden						
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mark	ř	19a. Informant's Name/Relation			19h N	Mailing Address	(Street a			al Route Number	City o	r Town 5	State Zin	Code)	
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Department of near an owner and years. Department of near an arower and repeated than the properties of the properties		20a. Method of Disposition	a), adagiir	20b.	Place of D	Disposition (Nam	e of	1							
		Burial 2 Cremation 3 Removal from State													
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mpo any i		21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061													
		23a. Part 1. Enter the disease, or complications that caused the death. Dinot enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
		shock, or heart failure. List only one cause on each line. Onset and Death Onset and Death													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 15 1- State Regi**Amend Item #11 Per INF 8848 10 Per #15** at the first Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUG 17 **Physician** Year ALVIN 2005 0637 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMIRE HOSPINAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Numb 7. Age (In yrs. last birthday) 45 Yrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 80 9195 1 M 2□F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23e or 28e-f show treumatic event, If a Mexical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hyglene. nnt: If Item 27 is marked other than "neturel", or Itel Widowed 4 ☐ Divorced 1 ☐ Yes 2 No Specify: BIAC / 16a. Decedent's Usual Occupation
(Give kind of work done during
life. DO NOT use retired)

FAB PRO 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) ROIAND 19a., Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD APT Health of Health of Health of Health of Health GIEN 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H Importent: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) -23-205 Name and Address of Facility Phillip A WEALHER FORD ES. PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 01.6ER S+ BAltimorie MB 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5ACTEREMIA Physician NEGATIVE /Medical Due to (or as a consequence of): Examiner SYMPRONE Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Year 4□Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes PINo 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident

sician and burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed after death, Director: Af

filled in by

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within 24 hours a To the Funerel C

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

investigation

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BATTMORE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 42634

PUTTE

29d. Date signed (Month, Day, Year)

30. Name and address of vers n who completed cause of death (Item 23a) (Type, Print) 301 57

31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

29a. Certifier

(Check only one)

32. Pegistrar's Signature

			1 - State of Marylar Registrar	nd / Depa <i>Cei</i>	artment of H	lealth and Death	Mental H	ygie 2 6 Reg. No		27750	
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	Examir	ner	4a. Facility Name (If not institution, give street and number) Baltimore Woshington Medical 5. Social Security Number 6. Sex 7. Age (In yrs.	Center	4b. City, Town, or Gler Bu	Location of De	MD	A	County of Dea Me An	ondel	
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	1			Hospi	tal Dr	Glenn	Burnie	MD	216	01	
200	Sta Registr		31. Date filed (Month, Day, Year) 32. Degistrar's Signal	K So	wer						

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Funeral Director	250	240-32-9675	<i>e</i> x 7. A □ M 2 🖾 F	ge (In yrs. last birthday,	Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	Birthplace (State or Foreign Country) NORTH CAROLIN			
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To the Funeral Director: completely filled in by the	Certifica											
To the Funeral Completely filled	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the bes piner: On the basis and manners	t of my knowledge, deat of examination and/or in tated.	h occurred at the tim vestigation, in my or	ne, date and place pinion, death occ	e, and due to the durred at the time, o	ause(s) and manne date and place, and	er as stated. due to the cause(s)			
Tot	ž	29b. Signature and title of certifier			29c. License	e number	7	29d. Date signed (M	fonth, Day, Year)			
4		O IV Var	My		D	1858	+	AUG I	7 2005			
`		30. Name and address of person who	completed cause of	death (Item 281) (Type,	Print)	N Ans	E BA	LTO Mi	21229			
Sta	te	31. Date filed (Month, Day, Year) AUG 2 5 2	32. R dis	rar's Signature	Z	- /10						

			for State Registrar	State of Ma	ryland / [Depa <i>Cen</i>	rtment of F tificate of I	lealth an <i>Death</i>	d Mental H	ygi 9		2	7752	
			1. Decedent's Name (First, Middle, Las							ath		3. Time of Death		
	Physici /Medio		Charles E.G	reene	reene				And	2	Day Y	ear OS	1221 PM	
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea					4c. County of	Death			
			Univ of Maryland	medical	Centa	V	Balt	mo	te		NIA	7		
	Funeral		Social Security Number 6. S		(In yrs. last bir	rthday)_	If Under 1 Year Months Days	If Under 24		Birth	ar) 9	Birthpi Coun	lace (State or Foreign	
п	Director		158-36-1493	M 2□F	58	Yrs.	Working Days	110010	Dec.	5, [Jersey	
-	put *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	m or loo	ention					4.		
	sho	7					ation					10	0d. Inside City Limits	
	Me M	Director	New Jersey Esse	X	Orange	2							1 ☐ Yes 2 XNo	
	with t		10e. Street and Number				10f. Zip Code			10g. (Citizen of Wh	at Coun	try?	
	s 23	Funerai	186 Parrow Street			1	07050				Lted St			
	er de Item	nue	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin' ın, Mexican, Pı	? (Specify Yes or fuerto Rican, etc.)	10-	14. Race - Black,	America White, e		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exameter mutter indiffer at 2008.	by F	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Const	1	☐ Yes 2X No	Specify:			Specify:	70.7		
21215-0036	tura		15. Decedent's Ec		162	Decede	ent's Usual Occupa	ation		106	Kind of Busin		ack	
15	in 72 n "n fedir	Completed	(Specify only highest gra	de completed)		(Give k	ind of work done of NOT use retired	during most of	working	100.	KING OF BUSH	ness/ind	lustry	
72	within liene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		orma		·		Bu	ilding	r		
g	filed Hygie other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Midd					
Maryland	lid be lental ked c	To B	James Greene					Mary G	riffin					
ary.	should nd Men marke umatic		19a. Informant's Name/Relationship (7	Type, Print)	19b	. Mailing	Address (Street a		r Rural Route Num	ber. Cit	v or Town. Sta	ate. Zip	Code)	
ž	and 2 ealth a n 27 le		Dr. Onaje Greene/	Son					urt, Lau					
Baltimore,	s 1 a f Hea item othe		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of		Date	_	Location - Cit		wn, State	
30	Pages nent of i int: If its iry or o		1 ABurial 2 □ Cremation 3 □ 3 4 □ Donation 5 □ Other (Specify				atory or other plac		29/05					
Ħ	permit. Page Department Importent: If any injury or once.		21. Signature of Euneral Service Licen		0321		Cemetery Name and Addres		29/03	Ura	inge, N	J		
Ba	permi Depa Impo any ir		MO VSISI	016	00321	Woo	dy Home	for Se	rvices		07050			
			23a. Part1. Eyjer the disease, or comp shock, by heart failure. List only	olications that caused the	ne death. Do r	not ente	the mode of dvine	g. such as care	Orange,	NJ	07050		Approximate	
ı,	2000000		shock, by heart failure. List only in Immediate Cause (Final	one cause on each line.				3, 000, 00 00,	and or roophatory	anost,			Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a. Depsis I week									week	
	Examiner			Due to (of as a	consequence	of):								
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequence of):										
1	nsit	Examiner	Cause (Disease or injury											
V	al-tra	Xar	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						-		
9	be e	a												
68760,	ificate be executed g physicien and as the burial-transit	edicai		. d.										
_	death certifi attending j	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date o	f dalivar		
Вох	death atte	cial	in the past 12 months? 1 □ Yes 2 □ No		1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					Month.	y Day Year			
P.O.	the or	Jys	9 Unknown	9□ Unknown										
٣	w requires that the death cer been signed by the attendir should be detached for use	Completed by Physician/M	Part II. Other significant conditions co	ontributing to death but	not resulting in	the unc	lerlying cause give	en in Part I.	23e. Did	tobacco	use contribu	ite to the	cause of death?	
rds,	puires n sign	Ω D	Stage IIB nor	Small ce	Il lun	va c	ancer		1	Yes	2□No 3[Proba	bly 4 Miknown	
<u>0</u>	w rec beel shou	ete			<u>_</u>				24a. Wa		24h Wos		au findings and italia	
Re	has ge 2	E							– auto	opsy formed?	prio	r to com	sy findings available pletion of cause of	
Division of Vital Record	n: Ti ficate r. pa		05 100						1X Yes	2 🗆 N	lo 1 🗓	Yes 2	2□ No	
⋚	sicia certi recto	Be	25. Was case referred to medical examiner?	Hospital:			2□ DO4 Othe		Death (Check only					
o	Phys r this ral di	P.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Out		3□ DOA 28c. Injury	4 L Nursing	g Home 5 Res			Specify)		
on	ding h. After fune	tion	1 Natural 5 Pending	(Month, Day Y		njury	Work	a` ∕es 2 □ No	20d. Describe	HOW III	ury occurred			
2	deat ctor: y the	Certification;	3 ☐ Suicide 6 ☐ Could not be		- At home fai	rm stree			28f Location	/Street	and Number	e Puml	Pauta Mumbas	
.≥	or A efter Dire	erti	4 Homicide determined	building, etc.	(Specify)	,,, 5,,66	n, raciory, omco		City or To	 Location (Street and Number or Rural Route Number, City or Town, State) 				
_	To the Hospitel or Attending Physician: The law requires that the death cert within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Phy	ysician: To the best of i	mv knowledge	death c	occurred at the tim	e date and nic	and due to the		a) and manage		Ad	
	24 hos Eur Fur etely	edical	(Check only 2 Medical Examone)	iner: On the basis of example and manner state	camination and	d/or inve	stigation, in my op	inion, death o	ace, and due to the courred at the time	, date a	s) and manne nd place, and	due to t	ted. the cause(s)	
	o the	Me	29b. Signature and title of certifier		-		29c. License	number		29d. D	ate signed (N	fonth. D	av Year)	
	F \$ F 0		DI VILLET	2 MMS	We	0	770	7110						
		-	30. Name and address of	omploted asset	th //ta= 52 \ 2	T	J 13	140		112	921.	, 26		
	H		Alaba I TAMES	completed cause of deal	th (Item 23a) (Ba Ba	Itm	vic mi) 2	120	1		
	Sta	0	31 Date filed (Month, Day, Year)	22 Pagietrar's	Signature			, ,			****	£		
	Registra	24	Allo o -		2.9.1									
DH	MH 17 Rev 1/20		AUG 2 5	2005 Have	in the		Cast 1							
				2005 Mars	ORIG	INAL								
						+ 00								

State of Maryland / Department of Health and Mental Hygiene Reg. 2.0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Wardell 1700 M Gordon 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Year) Sept. 22, 1935 Oklahoma If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days 1**X** M 2□ F Hours 69 Yrs. Director 447-34-7563 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a, State or 28a-f show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiens. It fail that the Americal Hygiens "natural", or Items 23s or 28a-1 shown it I faim 21 is marked other than "natural", or Items 23s or 28a-1 shown into or other traumatic event, Item Andrea Exc. eliter in the Compilied at my or other traumatic event, Item Andrea Exc. eliter in the Compilied at Director 1 X Yes 2 No 0klahoma Comanche Lawton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3348 Salinas Drive 73501 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Clothing Store Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Gordon Lela Reed ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 is
any injury or other trau Dorothy Gordon (Spouse) 3348 Salinas Dr., Lawton, OK 73501 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 8/25/05 Highland Cemetery Lawton, OK 21. Sign fure o Funeral Service Lice 199 22. Name and Address of Facility
Jefferson Funeral Home uman 101 W. Gore, Lawton, OK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Respiratory Dishess Syndrome 2 weeks /Medical Due to (or as a consequence of): **Examiner** Bacterial endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Paraontic Alosces S Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Ascending Aprilic Anerrysm 1 Yes 2 No 3 Probably 4 XUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 autopsy performed? Kenal Failure 1 ☐ Yes 2 1 W 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Dite of Injury
(Month, Day Year) 28b. Time of Injury
28c. 1 ☐ Yes 2X No Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature 29d. Date signed (Month, Day, Year) Kes -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600N Wolfe Storet Baltimore Mayland 21231 The Juhns Hapkins Hospital Gi. Christopher Frech 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 05

Months

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

11.mon14M

DUIFFRIDA

7. Age (In yrs. last birthday)

TOSPICE

6. Sex

1□ M 20 F

Certificate of Death

Reg. No. 2. Date of Death Month Year 10:50 PM AUGUST 23 2005

4c. County of Death

15AUTIMORE

Birthplace (State or Foreign Country)

Physician /Medical **Examiner**

Funeral Director

28a-1 show other traumatic event, the Medical Examiner must be notified at 'neturel', or iteme 23a within 72 hours after I Hygiene. le marked other ges 1 and 2 should be fill of Health and Mental Hill Item 27 le marked oth

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

Division

VIRGINIA GUIFFRIDA

2005

23,

AUGUST

Physician /Medical Examiner

funeral

for use as the burial-transit and signed by the attending physician director, page 2 should be detached been has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the

Examiner Physician/Medical þ Completed Be 2 Certification; cal

1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) STECLA 5. Social Security Number 212-14-3285 10a. Slate Director mD 10e. Street and Number 9217 by Funeral 11. Marital Status Completed Be DAWN Important: If Item eny injury or othresulting in death) Last IF FEMALE

9217 HARFORD AYBAR DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 066571 Burial 2 Cremation 3 Removal from State CARDENS OF FAITH 27, 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Feneral Service/Licer 22. Name and Address of Facility FUANS HARFORD 14Mble 23a. Part I. Enter the disease, or complicat shock, or heart failure. Vist only one is that caused the dea Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, I any, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a gonsecuence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

8. Date of Birth (Month, Day, 86 Yrs. MARYLAND 1918 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 10 BACTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 21234 DR HARFORD VIEW USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT DESIGNER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDGAR LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BACT, MO 21234 20c. Location - City or Town, State KOSEPALE CHAPEL FUNERAL PARKUI 11E Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Tes 2 No 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2**X** No Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) HOSPICE 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

Carles !

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Dale filed (Month, Day, Year) AUG 2 5 2005

	1- For Unpend Item 23a&27 per me G8		
Physician	Decedent's Name (First, Middle, Last) WALTER	HICKMAN 2. Date of I Month AUG.	Death Day Year 12, 2005 12:47 AM
/Medical Examiner	4a. Fecility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 217-82-1847 12 F 45	Months Days Hours Min. (Month, I	Birth Day, Year) 9. Birthplace (State or Foreign Country) 73 - 60 5. C.,
•how	Tou. State	own or Location	10d. Inside City Limits
r 286-f eh noutlied irector	MD, N/A BACI	T(MORE 101, Zip Code	1 10g. Citizen of What Country?
3a or 2 If De n	10e. Street and Number 1923 HOFFMAN STREET	21213	U.S.A.
within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28e-1 show he Medical Examinar must be notified at ompleted by Funeral Director		13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: BLACK
72 hours naturel' ical Ex	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
ed within 72 ho. ygiene. ver then "nature t, the Wedical E	Elementary/Secondary (0-12) College (1-4or 5+)	CONSTRUCTION	COMMERCIAL & RESIDENTIAL
ital H d oth	17. Father's Name (First, Middle, Last) 17. W. CA	18. Mother's Name (First, Midd RTOE ZEIDA	HICKMAN
~ 5 6 3	19a. Informant's Name/Relationship (Type, Print) ZEIOA HICKMAN – MOTHER	19b. Mailing Address (Street and Number or Rural Route Num	6. MD. 2/2/3
permit. Pages 1 and 2 Depertment of Health a Important: if Item 27 is eny injury or other tra ance.	20a. Method of Disposition 20b. Plac	e of Disposition (Name of Date etery, crematory or other place)	20c. Location - City or Town, State
t. Pag rtment rtent: f njury o	4 Donation 5 Other (Specify)	ENMOUNT CENETEM 8-22-05 22. Name and Address of Facility	BALTO. MD. 2431 E.OUVER ST.
Depermit. Depermit Import Impo	Phillo A Wantherfus	PHILLIP A. WEATHERFORD FUN. S.	er. BACTO.MD. HA13
	23a. Part1. Enter the disease, or complications that clused the death, shock, or heart failure. List only one cause or each line.	Do not enter the mode of dying, such as cardiac or respiratory	y arrest, Approximate Interval Between Onset and Death
Pnysician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhy Due to (or as a consequent	thmia due to Myocardial Fibr	
that the death certificate be executed to be the ettending physicien end detached for use as the burial-transit of Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence cause). Due to (or as a consequence cause).		
Attending Physician: The law requires that the death certific reasth. sctor: Atter this certificate hes been signed by the ettending p by the funeral director, page 2 should be detached for use as by the funeral director, page 2 should be detached for use as liffication; To Be Completed by Physician/Mec		eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
es that the ligned by be detacted by Physical by Physi	Part II. Other significant conditions contributing to death but not resulti	and the same of th	id tobacco use contribute to the cause of death?
aw require ss been sk 2 should b pieted b			☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
The law requir		, pe	utopsy prior to completion of cause of data?
Lician: The certificete ector, peg		26. Place of Death Check on	
Physic this ce al direc	1 XYes 2 No Hospital: 1 Inpatient 2 XEF		esidence 6 Other (Specify) be how injury occurred
To the Hospital or Attending Physician: The whithin 24 hours effer death, within 24 hourself of lifector. After this certificate he completely filled in by the funeral director, page Medical Certification; To Be Com	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Coulement 28. Date of Injury 2 (Month, Day Year) 28. Date of Injury 2 28. Date of Injury 2 28. Date of Injury 2 28. Date of Injury 2 28. Date of Injury 2 28. Date of Injury 2	Injury Work? M 1 Yes 2 No	n (Street and Number or Rural Route Number,
s effer si Direction by	4 Homicide determined building, etc. (Specify)	City or	Τόwπ, State)
To the Hospital or Attendi within 24 hours after death. Vithe Funerel Director: A completely filled in by the fr Medical Certificati	29s. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl one) 1 Medical Examiner: On the basis of examination and manner stated.	adge death occurred at the time, date and place, and due to the n and/or investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated ne, date and place, and due to the cause(s)
EEE G 9	S COL Circulus and title of cording	29c. License number O.C.M.E	29d. Date signed (Month, Day, Year) AUG. 12, 2005
To T com	29b. Signature and title of certifier Teach rules A -	0.0111.2	
Tot with Total Common	Zoulurus A		LAND 21201
State Registrar	30. Name and address of person who completed cause of death (Item 2 ABIULIAH AU 111 31. Date filed (Month, Day, Year) 32. Registrar's Signature	PENN STREET, BALTIMORE, MARYI	LAND 21201

State of Maryland / Department of Health and Mental Hygie 20.051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HERGEN ROEDER Day DUROTITY Year 1133 AM AUGUST 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Keswick CENTER BALTMORE MUUTI CARE BAZTIMERE CITY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2 🙀 F 212-40-4775 91 Maryland Director Usual Residence of Decedent with the Maryland 10b. County N/A 0a. State 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23a or 28a-f ahov vent, the Medical Examprer must be notified at Maryland Baltimore City 1 Yes 2 No Director 10e. Street and Number 4905 Belair Road 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ White 3X Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yr's College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 is marked off jury or other traumatic even William Α. Sporrer Cora Linthicum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hall - Daughter 210 Homewood Terrace Baltimore, MD 21218 20b. Place of Disposition (Name of comptery, crematory or other place)
Holy Redeemer 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 8/27/05 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** for wine Renal jears /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immunal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Due to o as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ sign be artery disease 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident investigation М 1 Tes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 2005 AUGUST 25 30. Na e and address of person who completed cause of death (Item 23a) (Type, Print) Charles St HARON J. CHARLES TOWSON MO 21204 ms 6601 31. Date filed (Month, Day, Year) 32. Registçar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygier 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** JOHNEN 23=37 M 20 2005 MARK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAURE DE GRACE HAZFOND 7. Age (In yrs. last birthday)
Yrs.

17 Age (In yrs. last birthday)
Yrs.

18 Days Hours Min.

19 Birthplace (State or Country)
Apr. 29, 1958 California HALFOLD HOSPITAL MEMEMAL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** X M 2 □ F Director 573-27-7479 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "neturel", or Items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at Rhode 1 XYes 2 No North Kingstown Washington Island 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 102 Cydot Drive 02852 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status OXYes 2□No Gulf 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: þ 3 Widowed 4 Divorced Year or Dates: War White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within nd Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Textron Industries Training Consultant 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Keifer Johnen Be Harry Jergen Jacobsen Klavelle Alice Meador 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jill R. Johnen/Spouse 102 Cydot Dr., North Kingstown, RI 02852 other t Baltimore, Aug 22, 2005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State ö * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Fagan-Quinn Funeral Home 825 Boston Neck Rd., North Kingstown, RI 02852 23a. Part 1. Enter the disparante shock, or hear failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final Priysician HASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Record Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No his 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 021809 Aug 20, 2005 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLABHU YORK LO TIMONIUM MO 21793 5 MD 2,336

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 5 2005

23.37

32. Registrar's Signature

1		State of Maryland / Department of Health a 1- State Unpend Item 23a&27 per me G847e9tiffcate5of Death		2. 0 0 0	27758
		1. Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
Physic /Med			Month AUGUS	r 18, 2005	ar
Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of		4c. County of D	
Jr.		BON SECOURS HOSPITAL BALTIMORE CI	TY	N/A	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hours	24 Hrs. 8. Date of Bir Min. (Month, Da		Birthplace (State or Foreign Country)
Director	4	Usual Residence of Decedent	JAN 3		MARYLAND
yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Marylar 28a-f show	tot	MARYLAND N/A BALTIMORE			MXYes 2 ☐ No
라 다. 8 2 8	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
ath w				U.S.A.	
(1215-50035) within 72 hours after death with the Maryland ene. then "natural; or items 23s or 28s-f show he Medical Examinar must be inclitined at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ori	gin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, /hite, etc.
rs aft	by F	1 Never Married 20X Married 1 Yes 20X No If Yes, Give 1 Yes 20X No Specify: Year or Dates:		Specify:	
2 hou	ed	15. Decedent's Education 16a. Decedent's Usual Occupation		BI 16b. Kind of Busine	ACK
Maryland 21215-0036 nd 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 le marked other then "natural, or r traumatic event, the Medical Exem	Completed	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) (Elementary/Secondary (0-12) College (1-4or 5+)	t of working	100. Kind of Busine	ss/moustry
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idal ylallad Z. I.Z. I. I. Should be filed within h and Menial Hygiene. 7 is marked other then "		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)			
Health		Gladys J. Jacobs/Wife 2047 Ruxton AVe., 20a. Method of Disposition 20b. Place of Disposition (Name of			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notitied at once.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
Definition of Sermit. Pages 1 are Department of Heal mportant: if Item in y injury or other upper.		4 Donation 5 Other (Specify) MT ZION CEMETERY 21. Signature of Funeral/Service Licens 22. Name and Address of Facility	18-25-05	LANSDOWNE	, MARYLAND
		WILLIAM C BROWN	COMMINITY	FUNERAL H	OME P.A.
		234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or	ENUE cardiac or respiratory ar	rest	Approximate
Physician	L	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Atherosclerotic Cardiovascular 1			Interval Between Onset and Death
of out, rate be executed by sicien and the burial-transit and	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
hat the death certific by the attending platached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23e. Did to	23d. Date of d Month	lelivery Day Year to the cause of death?
Oi Vital necords, Physician: The law requires t r this certificete has been signe	Pa		1□Y	es 2 ∑s Ño 3⊟	Probably 4 Unknown
e lawre has be	Completed by		24a. Was a	an 24b. Were	autopsy findings available completion of cause of
The I	E O		autops perfor	med: death:	/
ysician: Thysician: The is certificete director, pag	Be (25. Was case referred to medical examiner? 26. Place	of Death (Check only or		95 2 100
hysic this ca	၉	MYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	sing Home 5 Reside		pecify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ow injury occurred	
oitai or Al urs after o rai Direc		4 Homicide determined 288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Town		
To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the can occurred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
S T N		29b. Signature and title of certifier O C M E		9d. Date signed (MorAUGUST 19,	
Sta	te	30. Name and address of person who complet (suse of death (Item 23a) (Type, Print) 111 PENN STREET 31. Date filed (Month, Day, Year) 32. Projector's Signature	F, BALTIMORE	E, MARYLAN	D, 21201
Registr	ar	AUG 2 5 2005			
17 1/2		ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JEAN GILES JOHNSON 17, 12:00 a^M August 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 325 Davis Road Street Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/22/1922 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 219-34-0567 1 □ M 2 □XF Yrs Director Pennsylvania Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itams 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at Director MD Harford Street 1 ☐ Yes 2X No death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 Davis Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Be Completed by Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiene. em 27 is marked other ther 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sanford M. Giles ္က Janie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Robinson/Daughter t of Health a 1233 Sharron Acres Road, Forest Hill, MD 21050 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pagas permit. Paga Department o Importent: If any njury or any njury or 1 🔀 Burial 2 □ Cremation 3 □ Removal from State ō Clarks U.M.Church Cemetery 8/22/2005 Donation 5 Other (Specify) Bel Air, MD 21. Si sture of Fungral Service Licentee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 and. Effect the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician oronary Mease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be disease, 1 ☐ Yes 🕍 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes 2 No in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ၉ 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending after death. death. M 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C fillad Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aigNo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD nary rala 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar AUG 2 5 2005

State of Maryland / Department of Health and Mental Hygier 005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Mary Evelyn Kohlhepp August 18, 2005 9:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 💢 F Days Director 82 219-18-3573 June 19,1923 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow N?A Maryland Baltimore City Director 1 TYYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3704 Greenmount Avenue 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ Ho If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Voluntary Services V.A. Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Martin G. Schrufer Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 a Department of Health ar Important: if item 27 is any injury or other trau <u>once</u>. Mrs. Mary Ann Bacon - Daughter 19314 Cypress Hill Way Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) New Cathedral Cem 8/23/05 Baltimore. MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21214 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fire. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Thoracoabdommal months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sicien and burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Consestine 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 2X No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☑ No this After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injuly occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) , and who comp - cause of d= th (It= 23a) (Type, Print) GBMC 6701 N. Charles St. Balto MJ ZCZOY ID 31. Date filed (Month, Day, Year)/ 32. R sarrar's Signature State AUG 2 5 2005 Registrar

Timothy Kuczinski 05-05541 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item/23a, PII, 27, 28a-f, perme, 2846, 8/26/05 TT State of Maryland, Department of Health and Mental Hygien () 5

27761

 1-	For State Registre

Physician /Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 le marked other then "natural", or Iteme 23a or 28a-f ehow eny injury or other treumalic event, Tra Medical Exa ultrar must be nutified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

•	1 - State Registrer				Cei	rtificat	e of	Death		F	سط Reg. No		_		
	1. Decedent's Nam	e (First, Middle	, Last)							2. Date of Dea				3. Time of D	eath
ian	Timothy .	John Ku	czinski							Month Angust	16.		Year 5	0738	ΛМ
cal	4a. Facility Name (ımber)		4h City	Town o	r Location o	of Death	August	7	. County o		0730	A
ner			Carl W	impory					or Dougr					J_1	
	797 Jenn 5. Social Security N		6. Sex	7. Age (In yrs.	last histhday)	Seve If Under		If Under	24 Hrs.	8. Date of Birt		nne 1		JEL lace (State or I	Foreign
	212-76-80		12X M 2 ☐ F		Yrs.	Months		Hours	Min.	(Month, Day	y, Year)		Coun	try)	oreign
	Usual Residence of			46						3-04-19	159_		MD		
	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation							10	0d. Inside City	Limits
5	MD	A A	J ₋ 1											1 Yes 2	No No
ect	MD	Anne A	runaeı	Sev	ern	10f. Zip	Code				10a Cit	tizen of Wi	hat Coup	tn.2	
급	10e. Street and Nu												nat Coun	шуг	
by Funeral Director	797 Jenr	nie Dri				_	144		1.0.10	7 1/ 1/	U.S		A P.		
une	11. Marital Status		Armed F		1.5,	Was Dece If Yes, spe	dent of H cify Cuba	iispanic Ori an, Mexicar	igin / (Spe n, Puerto l	cify Yes or No- Rican, etc.)		14. Race Black	- Amenc , White, e		
Y	1 Never Marr		If Yes, G			1 🗆 Yes	2 XNo	Specify:				Specify:	Whi	ite	
	3 Widowed	4 XDIvorced	Year or t	Dates:											
Completed	(Spec	 Decedent cify only highes 	's Education it grade completed,)	16a. Dece	dent's Usu kind of wo	al Occup rk done	ation <i>during mos</i> d)	t of worki	ng	16b. K	and of Bus	iness/Ind	fustry	
ldu	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)	life.	DO NOT u	se retired	d)			_		_		
ပ္ပ	12				Carp	enter						arpen			
Be	17. Father's Name	(First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden	i Sumame)		
2	Stephen	Joseph	Kuczinsk	i, Sr.				Mari	an A	da Barr	y				
	19a. Informant's N	ame/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	er or Rura	il Route Numbe	r, City	or Town, S	tate, Zip	Code)	
	Mrs. Ra	mona L	ee Conroy	/Sister	797-	A Jen	nie	Drive	. Se	vern MD	21	144		i.	
	20a. Method of Dis				Place of Dispo			ca)		ate		ocation - C	ity or To	wn, State	
		☐ Cremation	3 □Removal from	i State	n Haveı	-			-20	2005	01	D		2500	
	21. Signature of Fu			/				ss of Facilit	-	ngleton		en Bu			
	DAM.	1/1/1/		1364	1					en Barn	fu	Mn 2	1061	e P.A.	
	220 Parti Fotori	the disease or		- 1								TID 2	1001	Approximate	
			complications that only one cause on	each line.	in. Do not on	.01 1110 11100	o or ayıı	ig, saciras	ou. diac c	, rospiratory ar	.031,			Interval Betwee	
	Immediate Cause disease or condition	on	a Inti	cacerebe	llar H	emori	hage	e							
	resulting in death)		Due to	(or as a conse	quence of):										
	Sequentially list of	anditions	b												
ner	Sequentially list co if any, leading to in cause. Enter Under	mmediate		(or as a consec	quence of):										
Ē	Cause (Disease or that initiated event	r injury s	С.												
Examiner	resulting in death)	Last	Due to	(or as a consec	quence of):										
cal			d												
Medical															
- 2	IF FEMALE: 23b. Was deceder	nt pregnant		utcome of pregn								23d. Date	of delive	ry	
clai	in the past 12	2 months?		birth 2 Feta mant at time of a		Ectopic p Other (se		y				Mont	th	Day Ye	ar
ys	1 ☐ Yes 2 9 ☐ Unknown		9□ Unki				,,								
Completed by Physician	Part II. Other signi	ificant condition	ons contributing to	death but not re	sulting in the u	nderlying (ause giv	en in Part I		23e. Did to	bacco	use contrib	bute to th	e cause of dea	ath?
d b	-		cation: I		-					101	es 2	□No 3	3 🗌 Proba	ably 4 Mun	known
stec		2007, 240, 240, 250	cataon, I	Aber rei	PTAG C	arun	vasi	curar				Т			
현	Disease	е								24a. Was autop	sy	24b. W	ere autor	osy findings av	allable ise of
ĕ											rmed? 2 □ No	de	aun?	2□ No	
Be	25. Was case refe	rred to medical						26. Place	of Death	(Check only o	ne)				
	examiner? 1⊠Yes 2□] No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 Do	Oth	er: 4 🗆 Nu	ursing Ho	me 5 Resid	lence	6 XOther	r (Specify	at sc	ene
Medical Certification; To	27. Manner of Dea		28a. Date	of Injury oth, Day Year)	28b. Time o		28c. Injur Wor			28d. Describe h					
100	1 □ Natural 2 □ Accident	5 🗌 Pendin investi	9	nth, Day rear)	Injury	м		rk! Yes 2. □	No						
fica	3 Suicide	6 ☐ Could	not be 200 Bloc	e of Injury - At h	ome, farm, st	reet, factor	v. office			28f. Location (5	Street ar	nd Number	r or Rura	Route Numbe	9 <i>r</i> ,
ert	4 🗌 Homicide	detein	build	ding, etc. (Speci	fy)					City or Tox	m, State	9)			
Ö.	29a. Certifier	1□ Cartifyir	ng Physician: To th	a bast of my ka	owledge deat	h occurred	at the tu	mo dato ar	nd place	and due to the	20100/0	\ and man	nor as st	atod	
Ica	(Check only one)	2 Medical	Examiner: On the	basis of examin	ation and/or in	vestigation	n, in my c	ppinion, dea	ath occurr	ed at the time,	date an	d place, ar	nd due to	the cause(s)	
Med	29b. Signature and	d title of certifie		TITIOT STATEG.		29	c Licens	e number			29d Da	te signed	(Month /	Day Yearl	
-	29D. Signaturo and	A	1000	\	1	23									
		wol	Mail	AUN	a		U.C	.M.E.		A	Augu	st 17	i, 20	ノしフ	
	30. Name and add	lress of person	who completed cau	use of death (Ite			tree	t, Ba	ltimo	ore, Mai	cyla	nd 21	1201		
te ar	31. Date filed (Moi		AY.	Registrar's Sign	ature	120									
rar	AU	G 2 5 20	JUJ KARA	as do	1										

Registrar

State of Maryland / Department of Health and Mental Hygie20051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lowder August 15, 2005 7:45 P M Bernice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Sept 11, 1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1 ☐ M 2 □ ▼F Hours Stanly, 240-24-8608 Sept Director 90 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show oligal Examiner must be notified at Annapolis 1 ☐ Yes 2X No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 764 Ballast Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercication. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Letha Mae Ralph Burleson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 E. Ocean View Ave. Unit #206 Norfolk, VA 23503 Marlene Dunn 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8-19-05 Pine Grove UMC Cem. 4 ☐ Donation 5 ☐ Other (Specify) Albemarle, NC 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hartsell Funeral Home P.O. Box 7, Albemarle, NC 28002 23a. Part. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition a. Myocardial infarction resulting in death) Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical as the b IF FFMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No ō 4☐ Pregnant at time of death 5 Other (specify) P.O. | by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 1 ☐ Yes 2 X No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 30 DOA ပ 1 Yes 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 V atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who; 8601 Veterans RINITERKE

DHMH 17 Rev 1/2001

State

Registrar

32. Bigistrar's Signature

AUG 2 5 2005

	•	1 - For State of Marylar Registrar	nd / D	epartment of Health and I Certificate of Death		gie2005	27763
		Decedent's Name (First, Middle, Last)			2. Date of De	aath	3. Time of Death
Physicia /Medic		Ernest Loggins			1 /1	St 32 200	5 1025AM
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	h (a t	4c. County of Dea	th
Funeral	Ç.	NORTHWEST HOSPITA L 5. Social Security Number 6. Sex 7. Age (In yrs.	. last birti	hday) If Under 1 Year If Under 24 Hrs.		th 9. Bir	thplace (State or Foreign
Director		218-09-1641 1XM 2 F 92	`	Yrs. Months Days Hours Min.	09 25	iy, Year) C	MD
and w		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity. Town	or Location			10d. Inside City Limits
Maryli f sho	to		•	allstown			1 ☐ Yes 2√ No
h the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
ath will		9835 Winands Road		21133		U.S.	
be lied within 72 hours after death with the Maryland trail Hygiene. A property or items 23a or 28a-f show event, it a Madical Extrainer met be natified.	Funeral	11. Marital Status 12. Was Decedent Ever in UArmed Forces? 1 Never Married 2 Married 1 Yes 3/0 No	J.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Am Black, Whi	
urs at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ※☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 【XNo Specify:		Specify:	Black
72 hours "netural".	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupation (Give kind of work done during most of work	rking	16b. Kind of Business	
be tiled within 72 ho tal Hygiene. Id other than "netu event, tre M. alcal	ldmo	Elementary/Secondary (0-12) College (1-4or 5+) 9th grade na		life. DO NOT use retired) Security Officer		Baltimore Electric	
tiled Hygie other		17. Father's Name (First, Middle, Last)			ne (First, Middle	, Maiden Sumame)	oopuri
2 should be tiled within and Mental Hygiene. Is marked other than aumatic event, ILEM.	To Be	Bradley Loggins		Emma L	oggins		
2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Number or Ru	iral Route Numb	•	
permit. Pages 1 and 2 should Department of Health and Men Importent: If tiem 27 is marke eny injury or other traumatic. 20168.		Ernest W. Loggins-Son 20a. Method of Disposition 20b.		35 Winands Road, Disposition (Name of	Randa.	llstown, I	
Pages nent of H ont: If ite		Naturial 2 ☐ Cremation 3 ☐ Removal from State	cemeter	y, crematory or other place)			
nit. Partme artme ortent injury		21. Signature of Emperal Service Licensee	rryr	and National 8/2 22. Name and Address of Facility	5/05	Laurel,	MG
permit. Department importer on yinju		Kirrette K. Anes		March F/H West 4300 Wabash Ave	, Balt:	imore, Md	21215
		23a. Part 1. Enter the disease, or complications that caused the dee shock, or heart failure. List only one cause on each line.	eth. Do n	ot enter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	/F	CEREBROVAS	SCUL	AR	Onset and Death
/Medical Examiner		Due to (or as a conse	quence o				
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consecution)		~ /			
cuted and and areasit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c					
icate be executed physician and s the burial-transit	I Ex	resulting in death) Last Due to (or as a consec	quence c	of):			
icate l	edlcal	d					
leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		205-10-1-1-1-1-1		23d. Date of de	livery
death	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
w requires that the de been signed by the should be detached		9 Unknown Part II. Other significant conditions contributing to death but not re	sulting in	the underlying cause given in Part I	23e Did t	tobacco use contribute to	the cause of death?
signe d be d	d by	Part II. Othat significant conditions contributing to death but not re	sulling in	the didenying cause given in Parti.	1 🗆		robably 4 Unknown
w requ	lete				24a. Was	an 24b. Were a	utopsy findings available
The lay te has age 2	Completed				auto	psy prior to death? 2 ▼No 1 □ Yes	completion of cause of
icien: The certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only		Subacute
Physic Physic this ce	은	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Out		lome 5 Resi		city unitat
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after dash. To the Funerel Director: After this certificate has been signed by the attending physicompletely tilled in by the funeral director, page 2 should be detached for use as the	Certlfication;	27. Manner of Death Shatural 5 Pending (Month, Day Year) 2 Accident Investigation	28b. T	Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe	how injury occurred	Northwest
Atten r deal ector: by the	Ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At h	home, far	rm, street, factory, office	28f. Location (City or To	Street and Number or R	ural Route Number,
rs afte	Cert						
Hospi 4 hou Funer fely till	Medical	29a. Certifier 1 Certifying Physician: To the best of my kn (Check only 2 Medical Examiner: On the basis of examiners)	nowledge lation and	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the irred at the time,	cause(s) and manner at date and place, and due	s stated. e to the cause(s)
o the vithin 2 o the	Mec	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
F × F 0		Mrudine Karuhi		62912		August:	22005
1		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)		7.1.	110
. (CHRISTINE KAJUBI	54	FOI OLD COURT	ROAI	D, NW	ItC
Sta Registr		31. Date filed (Month, Day, Year) AUG 2 5 2005 32. Registrar's Sign	iature				
DHMH 17 Rev 1/2	-	Mod & J 2003 Follow	D	god			
			ORIO	GINAL			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 005State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year PHILIP LEONARD LORBER AUGUST 22,2005 2:40 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical **Examiner**

4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/27/1927 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 1 M 2 □ F Yrs. 217-22-8232 Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, If a Medical Exertiner . ust be notified at Director MD BALTIMORE PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2812 JOMAT AVENUE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then HOME IMPROVEMENTS Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE CONTRACTOR permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If tem 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES A. LORBER 2 NINAH REULING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARKVILLE, MD 27234
Phate 20c. Location - City or Town, State EVANGELINE ANNE LORBER/WIFE 2812 JOMAT AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GARDENS OF FAITH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 8/26/2005 PARKVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a GASTROINTESTINAL BLEED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner THROMBOCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit . ACUTE WAEFOID FERKEWIU and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician NON HODGKIN LYMPHOMA Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 4□Pregnant at time of death ☐Yes 2 ☐ No. 9☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/ No Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2125 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM M. OSLER DRIVE 7601 TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) Goarle 2. Registrar's Signature

Registrar

AUG 2 5 2005

	4.		For State Amend Items 2 Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland 6,29c,d,30 pe	r Depa	imment of the 34 thicate of	Death	Date of De	ath		27765 3. Time of Death
	Physici		Ralph B. Lingeman					Month		Year	2:45 PM M
	/Medic Examin	_	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Death		4c. County		
		ege A	Suburban Hospital			Betheso			Montg		9
*	Funeral Director		305-36-1921	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da Mar 8,	y, Year)	9. Birthp Coun Flor	lace (State or Foreign try) ida
	death with the Maryland ims 23a or 28a-f show ims 25a or 28a-f show	tor	Usual Residence of Decedent		, Town or Lo					1	0d. Inside City Limits
	with the	i Director	10e. Street and Number 5914 Johnson Aver	•		10f. Zip Code	20817		10g. Citizen of W		ntry?
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiane. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Marical Examinat man its analitied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 144-		Was Decedent of f Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	k, White, Wh	ite
ಿ ಓ 21215-0036	2 should be filed within 72 hr and Mental Hygiene. Is marked other than "natu eumatic event, tre Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+) 5+	(Give	dent's Usual Occu kind of work done DO NOT use retire physic	during most of world)	king	16b. Kind of Bu	siness/Ind	,
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3c ylai	Menta Menta arked artic e	To	Ralph Burgess L		T				Hippenst		
) 30 Maryland	2 short and le m		19a. Informant's Name/Relationship (Typ				t and Number or Ru		-		Code)
	1 and Health em 27 other tr	3	Carolyn Lingeman/s	20b. P	lace of Dispo	sition (Name of	Avenue B	Bethesda Date	MD 20 20c. Location -	~ ~ ~	own, State
JYH, altimore,	Pa men ent: ury		1 Burial 2 Cremation 3 Re 4 Donation 5 Description 21. Signature of Foneral Service License	emoval from State		natory or other pla					
Bal	permit. Departr Imports eny inj			ace Mrecken	2	tate Ana	ess of Facility Itomy Boar . MD 212	rd 655 W	. Baltin	nore	Street
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eman, \mathcal{Q} ulph $$ 8 ivision of Vital Records	The law ate has b page 2 st	Completed						24a. Was auto perfo 1 \(\text{Yes}	an 24b. V psy prmed?	Vere auto prior to co death?	psy findings available mpletion of cause of 2 No
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			30. Name and address of person who co								
	AST CONTRACTOR		Dr. Kenneth Golds	stein, 2141 K	Stret	, N.W.,	#707 Wash	ington,	D.C. 20	037	
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 5 2005	32. Registrar's Signa	A CON						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydien 2005

		1 - Registrar 1. Decedent's Name (First, Middle, Las	23a per Dr.,G	Certificat	e of Death	2. Date of Deat		3. Time of Death
Physi	ician	Cherise E. Le				July 2	7, 2005	7:17 PM M
	dical	4a. Fecility Name (If not institution, give		4b. City.	Town, or Location of Deat		4c. County of Dee	
Exam	niner	11234 Evans 5	and the second s		ltsville		Prince G	eorge's
		5. Social Security Number 6. Se		st birthday) If Under	1 Year If Under 24 Hrs			thplace (State or Foreign
Funer: Directo			□M 2 🖁 F 34	Yrs. Months	Days Hours Min.	June 20	, 1971 Ne	vada
and	8	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
danyi f sho	5	ND Designation	James 1 a	Beltsvill	Δ			1 ☐ Yes 2 ☐ No
the t	Director	MD Prince (seorge s	10f. Zip		10	0g. Citizen of What C	ountry?
with	<u> </u>	11234 Evans Tra:	i1 #4		20705		USA	
eath	era	11. Marital Status	12. Was Decedent Ever in U.S	i. 13. Was Dece	dent of Hispanic Origin? (S city Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am	
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in 72	Completed	(Specify only highest grades)	de completed) College (1-4or 5+)	(Give kind of wo life. DO NOT u	rk done during most of wo se retired)	orking		
with iene.	E O	Elementary/Secondary (0-12)	nk					
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id be ental ked o	ToB	Steven A. Levey			Melba C	astelland	s	
shou nd M mar	1F	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing Address	(Street and Number or R			Zip Code)
IVIC IN 2: Ith at Ith at 27 is		Steven Levey/fat	her	11234 Eva	ns Trail #4	Beltsvill	Le, MD 20	705
tan Hea	1	20a. Method of Disposition	20b. Pla	ace of Disposition (National Action)		Date	20c. Location - City of	r Town, State
ages and of t: Hill		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Specify	Removal from State	metery, cremetory or t	 	U		
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		shock, or heart failure. List only	one cause on each line.				,	Onset and Death
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/Medic Examin		resulting in death)	Due to (or as a consequ	ence of):				2 ,,,00%
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To tha Hos within 24 h To tha Fun	2	29b. Signature and title of Pertifier	1/1/00 10	29	c. License number	2	29d. Date signed (Mo)	oth, Dey, Year)
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		10 Jecest 01	per ""	00a) (T. a. B.:)	000101	/	0/10/	
		30. Name and address of person who	completed cause of death (Item		-com R-	PHE 12	SILVERS	ORIVE. MD
		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	GROVE KO	12105	JIVE /	20901
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () 5 1- State Registraramend item #1 PER PHY G846 8 Partificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death VIVIAN HELEN LARKIN Day Month Year Physician August 23,2005 8:44 A Vivian - Larkin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK HOSPITAL MEMORIAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1□ M 2 F 89 Yrs. MO 217-03-9402 OECEMBER 12,1916 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in then "natural", or Items 23s or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD CARROLL ELDERS BURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 4.5.A, SHERRYL 3032 AVE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status is 1 and 2 should be filed within 72 hours atter of Health and Mental Hygiene. Item 27 Is marked other then "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT WAITRESS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ETHEL MCCOMAS CHARLES LEE YOUNKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NEPHEW 2032 SHERRYL AUE. ELDERSBURG MO. 21784 JOSEPH L. CAMBY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MORELAND MEM PARK A46, 26, 2005 BALTIMORE MO 21. Signature of The I Service Licensee 22. Name and Address of Facility MARZULLO FUNERAL CHAPEL LFO 6009 HARFORD RUAD. BALTIMORE, MO 2/2/4 23a. Part 1. Inter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn faithere. List only one cause in each line. Approximate Interval Between Onset and Death Immediate ause (Final disea a or ondition resulting in death) ALUTE MYUCARTIM Physician INFARCTION /Medical Due to (or as a consequence of): Examiner A.S. C.V.D 10 425 5.c. antially list can dians if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1 🗌 Yes 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760.

death with the Maryland

Baltimore, Maryland 21215-0036

signed by the attending physician and d be detached for use as the burial-transit at or Attending F s after death. I Director: After d in by the funera After e Hospital o 124 hours aff Funeral Di To the within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 23/05 D-31912 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIUS FREDERILU, MD 4WORMU22090 4021 ILLIO MENOCAL, ND

Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 5 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydier 0.0 5

		1	For State Of Marytanic State Registrer	Cei	rtificate of L	Death		eg. No.	21100
	Dhuaiai		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	
	Physicia /Medic		WILLIAM ARTHUR McWAYNE				August	20 2005	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	
			UPPER CHESAPEAKE MEDICAL CENTER		BELAI	R If Under 24 Hrs.	0.5-4	HARFO	
	Funeral Director		5. Social Security Number 6. Sex 1		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV . 16		irthplace (State or Foreign Country) MARYLAND
	ter death with the Maryland Items 23a or 28a-f show Items Items Collined at	or	10a. State 10b. County 10c. City,	, Town or Lo			_		10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	28a-	Director	MARYLAND HARFORD CO	ED	GEWOOD		1	0g. Citizen of What (Country?
	with ga o		819 OLIVE BRANCH CT.		210	140		U.S.A.	
	Jeath Tris 20	Funeral	11 Marital Status 12. Was Decedent Ever in U.S	3. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - An	nerican Indian,
21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show edical Ever in set mark be notified at	ρ	Armed Forces? 1 ★ Never Married 2 Married 1 ★ Never Married 2 Married 1 ★ Never Married 2 Married 1 ★ Never Married 2 Married 1 ★ Never Married 2 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 1 ★ Never Married 7 Married 7 Married 1 ★ Never Married 7 Married 7 Married 1 ★ Never Married 7 M	i		Specify:	Hidan, etc.)	Specify: B	LACK
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215	~ * W	nple	Elementary/Secondary (0-12) College (1-4or 5+)						
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3	should be ind Mental marked o	P	JAMES KEEL 19a. Informant's Name/Relationship (Type, Print)	19h Maili	ng Address /Street		E MCWAYN	r, City or Town, State	Zin Code)
Maryland	2 a a		Eddie Lewis Jr./Brother					ir, Maryl	
	s 1 and 3 if Health item 27 other tr		20a Method of Disposition 20b. Pl	ace of Dispo	osition (Name of			20c. Location - City	
Baltimore,	9 = 5		1 XBurial 2 Cremation 3 Hemoval from State		matory`or other plac JNT_CEMETE		26-05	BALTIMORE	, MARYLAND
圭	7. 5. 5. 5		21. Signature of Funer Service Lice 14-9	2	A Name and Address	es of Eacility	2010-1-100-1-1		
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io	andin sath. or: Af he fur	atlc	2 Accident investigation		M 1	Yes 2 □ No			
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	To t To t	Σ	29b. Signature and title of certifier.		29c. Licens	1	7	29d. Date signed (Mo	mur, Day, Year)
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ı	A dr		30. Name and address of person who completed cause of death (Item					01014	
	1		Dr. Feing Xiao, MD., 500 Upp			DR., Bela	ar Md.,	21014	
	St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Refistrar's Signa	St. J	parte				

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meWayne, William

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Exami Funeral Director	iner I	4a. Facility Name (If not institution, give street at The John's Hooking 5. Social Security Number 6. Sex 214-60-5198	ns Hospita 7. Age (In yr. last birth	4b. City, Town, or I Baltim If Under 1 Year Months Days	ore Cit If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Year Oct. 13, 1) Coun	lace (State or Foreign
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he Man 8e-f sh otilied	Director	Maryland	Baltim					1 No 2 No
3s. or 2	Dir	10e. Street and Number 3925 Beech Avenue, Ap	st 512	10f. Zip Code 21211			itizen of What Coun	•
I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumetic event, the Madical Examires must be notitied at	/ Funeral	11. Marital Status 12. Wa Am 1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces? Yes 2 XNo es, Give	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Speci , Mexican, Puerto Ri Specify:	ify Yes or No-	14. Race - America Black, White, e	an Indian, etc.
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t and 2 s Health an tem 27 is		Mary J. Corey (Friend		20 Beech Ave				C00e)
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iit. Pa artmen ortent: injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Bayview	Crematory	-		ltimore,	•
Physician /Medical Examiner		resulting in death)	that caused the death. Do no	CARINII F	onia Road.	Timonium respiratory arrest,	, MD 210	
ficate be executed physician and sthe burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	oue to (or as a consequence of					
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he Hospi n 24 hour he Funer pletely fill	edical	(Crisck Only 2 Medical Examiner: Of	To the best of my knowledge, the basis of examination and dimanner stated.	death occurred at the time /or investigation, in my opin	e, date and place, an nion, death occurred	d due to the cause(s at the time, date an	s) and manner as stand due to	ited. the cause(s)
To t To t com	Σ	29b. Signatore and title of tertifier	1 110	29c. License		1	ate signed (Month, D	*
Λ.)		30. Name and address of person who complete	d cause of death (Item 23a) (1	D472			124/200	
81		Carol Ann Huff, M.D.	Johns Hopkins	Hospital 1650	Orleans St	. Ste 209	Balto, M	d. 2123/
St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	F. N.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5

			1 - For State Registrar	State of M	arylan	d / Depa <i>Cer</i>	artment of H	ealth a	and Men		en () () () () () () () () () () () () ())5	2777	10
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	Examin	er	4a. Facility Name (If not institution, give		}		4b. City, Town, or		of Death		4c. County	of Death		
			9539 Kingston Place				Frederic		0.411					
	Funeral		5. Social Security Number 6. Sec	(7. A (M 2 F	ge (In yrs. I 58	last birthday) Yrs.	If Under 1 Year Months Days	If Under:	Min. (Date of Birth Month, Day,	Year)	Cour		
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land	A w		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City	Limits
Man	F P P	to	Maryland		Fre	derick	r						1 ∑ Yes 2	2 🔲 No
the	r 28e	irec	10e. Street and Number		TIC	deller	10f. Zip Code			10	g. Citizen of	What Cour	ntry?	
- X	23e c	al D	9539 Kingston Plac	ce			2170	1			U.S.A.			
deat	ems	Funeral Director		12. Was Decedent	Ever in U.	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Orig	gin? (Specify		14. Rac	e - Americ		
after 5	or Ite	/Fu	1 ☐ Never Married 2 X Married	Armed Forces 1 X Yes 2 ☐ If Yes, Give	$\sqrt{162/6}$	700	Yes 2□ No	Specify:	i, Fuello Rica	11, 6(0.)		ck, White,	etc.	
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7 Pell	Hygi ther ant,	o C	17. Father's Name (First, Middle, Last)	J1		At	torney	18. Mothe	er's Name (Fil		Law laiden Suman	ne)		
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should be filed within 72 hours after death with the Marvland	f Health and Mental Hygiene. item 27 Is marked other than "neturel", or Items 23e or 28e-f ehow other traumatic event, the Medical Examiner must be notified at	ř	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street a				City or Town.	State. Zip	Code)	
2 2	27 Is r trau		Shelley Musmanno	(Wife)			Kingston						/	
ָרָ קָּרְ	f Hez item othe		20a. Method of Disposition			lace of Dispos	sition (Name of natory or other place		Date		Oc. Location		wn, State	
Page	nt: If		1 X Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		-	ion Ceme		8/25/	2005	Moon T	ัพก	РΔ	
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i	hysician /Medical xaminer		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as	12 J~	.(er the mode of dying	g, such as	cardiac or res	spiratory arre	st,		Approximate Interval Betwe Onset and De	
DIVISION OF MEANING PRESIDENT THE DESCRIPTION OF THE HOSPITED OF Attending Physician: The law requires that the death cartificate he executed	ohysician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
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the death cert	been signed by the attending pt should be detached for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)					te of delive onth	nry Day Yea	ar
sthat	ned t		Part II. Other significant conditions con	tributing to death	but not resu	ulting in the ur	nderlying cause give	en in Part I.		23e. Did toba	acco use cont	tribute to th	e cause of dea	ath?
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Ţ	To con	Σ	29b. Signature and title of certifier	~	24		29c. License	number	21	29	d. Date signe	d (Month.	Qay, Year)	
			30. Name and address of person who co			23a) (Type,		1	- ,		7 =	- 1 .		
			DR. Jettrey Cower 31. Date filed (Month, Day, Year)	11112	310 M	lest o	1"St. F	redi	erick	-, MC	160	701		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $\bigcirc \bigcirc \bigcirc \bigcirc$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Barbara Elizabeth Mekolon 2005 20, 6:26 A August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 95 Delmar Avenue <u>Dundalk</u> If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 💢 F 218-48-2076 Sept. 18, 1947 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 95 Delmar Avenue United States t2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 21☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Years Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Rodgers Marie Kocur 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert J. Mekolon, Sr. 95 Delmar Ave. Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 31 Other (Specify) Christ Lutheran Cemetery 8/24/2005 Dundalk, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Tuneral Service Licenses Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION -3 ATHEROSCLERETIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETES MELLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10015022 08/22/05 marian, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEDOULO J. PAGLINAYAN. 617 STEMMERS RUN RD. UNIT-E, BALTO., M-D 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 5 2005

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State

Registrar

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica

Physician

/Medical

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Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0036

State of Maryland / Department of Heal	lth and Mental Hygie 2005	

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			Franklin Squa	are Ho	spital	Center		Ros	se da L	e			1	3a /tin	nore	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs		If Unde Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth av. Year)	9. B	irthplace (St.	ate or Foreign
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:≌	ol or Attend after death Director: /	ţ		etermined	28e. Place buildir	of Injury - At I	nome, farm, st	treet, facto	ry, office		2	8f. Location (City or To	Street and wn, State)	Number or I	Rural Route I	lumber,
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	To the Hospitel within 24 hours a To the Funerel Completely tilled	Medical	29a. Certifier 1 Certifier 2 Med one)	tifying Phys dical Examin	sician: To the ner: On the ba and mann	best of my kn asis of examin ner stated.	owledge, dea ation and/or in	th occurred rivestigation	d at the tim n, in my op	ne, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) a date and	and manner a place, and du	as stated. ue to the cau	se(s)
	To the To the Comp	Σ	29b. Signature and title of co	ertifler 2	e 1	1.D		29	c. License	-	0	, ,	400	signed (Moi		
				1100	//	1 17			D-	38	+5	4.	08	- 20	-2	005
	į		30. Name and address of pe	rson who cor	mpleted caus	e of death (Ite	m 23a) (Type	, Print)				Ba Hi				
	6		Dr. Malika	Was	eem c	7000 F	-roink	LIN S	DOLLE	re T	DEIVE S	Ba Hi	more	Md	21227	
	Sta	ite	31. Date filed (Month, Day,		32. R	egistar's Sign	ature in	hea	Med !		1110	JW 111	1017		-/ -/	
	Registr	2	A	UG 2 5	CUUS	Margara .	الحاقم مما	300								

31. Date filed (Month, Day, Year)

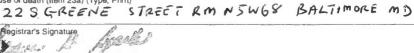
AUG 2 5 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asiegsu

BENEDICT ASIEGBU

32. Registrar's Signature



21201

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Р Physician 23, 2005 9:05 August Catherine Morcomb Elvira /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2**X** F NY Sept. 6, 1930 74 Director 063-24-6990 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b County 28a-f show the Medical Exactiner must be notified at 1 ☐ Yes 2X No Director MD Reisterstown Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or USA 21136 205 Janet Court Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 0 1 ☐ Yes 2 X No Specify: Specify: ρ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 other or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be James DiCicco Mary Caputo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Janet Court, Reisterstown, MD 21136 Ross R. Morcomb Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. Cem 8/29/05 Owings Mills, MD 21. Signatur of Funeral Servis Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Line Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cumtus Physician CLIO BCAS roma MULTIFORME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Dav in the past 12 prioriths? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate To the Hospitei or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury 1 X2 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building. etc. (Specify) completely filled in by 4 | Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10

State Registrar

31. Date filed (Month, Day, Year) AUG 2 5 2005

29b. Signature and tipe of certifier

Son 32. Registrar's Signature DESSES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6601 N. Charles St

29c. License number

D58303

COM WILMOT

29d. Date signed (Month, Dev. Year)

AUGUST 24 2005

			1 - State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death		2005	27775
	Physici	an	1. Decedent's Name (First, Middle, Last) Irene G. Murphy			2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death	August	23, 2005 4c. County of Dear	2:40 P. M
		*	Bradford Oaks Nu		Clinton		Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 176 16 9706	M 2 T F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign buntry)
	ס		Usual Residence of Decedent			Oct 31,	1920 She	enandoah,PA
	darylar f show	ō	Marylnad Prince Ge	eorge's Upper M				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Co	
	ath wit	ralD	9116 Dandelion		20772	Ţ	Jnited Stat	es
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "neturel", or Items 23e or 28e-f show amy injury or other traumatic event, I're Madical Examiner must be multified at ODGe.	by Funeral	11. Marital Status 1 X Vever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2√G/No	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※XXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
2-0	72 hou		15. Decedent's Educ (Specify only highest grade	ation 16a Dece	dent's Usual Occupation	ina	16b. Kind of Business/	
121	within ene. than "	Completed	Elementary/Secondary (0-12)		kind of work done during most of work DO NOT use retired) Homemaker	9	Own Home	
d 2	e filed at Hygi other vent, L	Be Cc	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, N		
Maryland 21215-0036	ould by Menta	ToE	Anthony Dugan			mbrowsky		
Mar	nd 2 sh Ith and 27 le m ' traum		19a. Informant's Name/Relationship (Type Terri Murphy (Daug		ng Address <i>(Street and Number or Rura</i> 5_Dandelion Lane,		,	,,
Jre,	of Hea	1	20a. Method of Disposition	20b. Place of Dispo	position (Name of matory or other place) Aug 26,		20c. Location - City or	
altimore,	Page tment tent: If	1	↑ Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	Resurre	ction Cemetery		Clinton, M	lary1and
Ba	Depar Impor any ir		21. Signatur & Funeral Serve License	at 100257	2. Name and Address of Facility Lee Alexandria Ferry R	d, Clint	on, MD 20	6633 01d 735
Y	100		23a Fay(1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	1,000	4	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	inter Disease			1 mmth
	Examiner		Sequentially list conditions, b					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):		<u>-</u>		
38760,	cate b physic s the b	dical	d					
Вох 6	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Tectorio proposo		23d. Date of del	ivery
O. B	0 0	/slcia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year
Δ.	that the ed by detac	y Ph	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	law requires as been sign 2 should be	ed by				1 ☐ Ye	s 2 No 3 Pr	obably 4 Unknown
Records,	e law re has be je 2 sho	Completed				24a. Was ar autops	y prior to o	topsy findings available completion of cause of
Vital F	Th ate pag	e Cor	25. Was case referred to medical				No 1 ☐ Yes	2 □ No
f Vi	S S	To B	evaminer?	ospital: 1 Inpatient 2 EN/Outpatier	26. Place of Death Other: 4 Nursing Ho		nce 6 □Other (Spe	city)
on of	ding Phy I. After thi funeral		27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time o	f 28c. Injury at Work?		w injury occurred	
Division	l or Attending after death. Director: Attel in by the fune	Certification:	2 (Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No reet, factory, office		reet and Number or Ru	ıral Route Number,
Ö	itel or rs afte el Dire	Cert	4 - Holling	building, etc. (Specify)		City or Town		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ledical	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the best of my knowledge, deat ler: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To To t	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Monti	
,	- 74		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	D35206	<i>P</i>	inquist 24, i	2005
	$\mathcal{Y}_{\mathcal{D}}$		William Tanner, M	.D. 11701 Livingsto	·	Washing	ton, MD 20	0744-5126
5	Sta Registi		AUG 2 5 2005	32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 2 1 5

			1 - For State Registrar	Otate of Wi	arytana / i		rtificate of			ziilai i i	Reg. I		411	10
	Dhusisi		1. Decedent's Name (First, Middle, L.	ast)					1	2. Date of D	eath		3. Time	of Death
H	Physici /Medio		Marie Helen Mc	Gehee						Month Augus		22 2005	3:00	P M
	Examir		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Locatio	n ol Death		4	4c. County of Dea		
			Millenium Nursi				Glen B		_				Arunde	1
	Funeral Director		219-14-9954	Sex 7. Ag 1 M 2	91	rthday) Yrs.	If Under 1 Year Months Days	If Und Hours	er 24 Hrs. s Min.	B. Date of B (Month, D March	irth ay, Yea	9. Bit 1914 MI	thplace (State ountry))	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	cation					<u>.</u>	10d. Inside	City Limits
	Maryll f sho	ō	MD Anne A											s 2 No
	the 288	Directo	10e. Street and Number	runder	GTEI	ı Dı	rnie	<u> </u>			10a (Citizen of What C		X
	3a or	Ö	1108 A Castle H	arbour Way			2106	0				U.S.A.	ourny:	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H		Origin? (Spec	ify Yes or N		14. Race - Am	erican Indian,	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "neturel", or Items 23a or 28a-f show eumatic event, the Madical Exant art must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give X Year or Dates:	No		f Yes, specify Cubi 1 ☐ Yes 2 ☑ No			ican, etc.)		Black, Whi	te, etc. whit	e
ئ ا	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation	16a	Dece	dent's Usual Occup	ation	net of working	•	16b.	Kind of Business	/Industry	
7	ithln Je.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) _		kind of work done DO NOT use retired		ost of working	,				
7	ygier ygier har th	S			Re	egis	tered Nu					lea1thcar	e	
	ba fi tal H od otl	Be	17. Father's Name (First, Middle, Las						ther's Name (,		
\equiv	should ba nd Mental marked c	L 2	Ernest Trumpowe		1.00				Adeli					
<u>a</u>	7572		19a. Informant's Name/Relationship				ng Address (Street							
<u>က်</u>	s 1 and if Health item 27 other tr		Mr. James O. McG	enee/nusbar			A Castle	нат	Dour Wa			Location - City or		60
و	0 0		1 ☐ Burial 2 X Cremation 3 [cemete	ry, crer	natory or other place	1						
			' 4 □Donation 5 □Other (Special Signature → Fotheral Service Lice		Chesap		e Cremat					evensvil		
g	permit. Departr Imports any inj		histing a	en Ole · M	01319	1	Second A	Avenı	ue S.W	., G1e	en B	urnie, M	D 2106	1
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each in	10.	4				4		1 -	Approxima Interval Be	ate etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	althoro	3 claso	w	coronar	MI	rasci	reas	d	Merso	Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):								
		-	Sequentially list conditions,	b. Due to (or as	a consequence	of):								
	ted	n lu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	OI).								
	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c	a consequence	ol):								
09/89	siciar buri			or al										
200	ificate g phy as the	Medical		d										
O. BOX	uires that the death certificate be executed is signed by the attending physician and id ba detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	′				23d. Date of de Month	ivery Day	Year
7.	that the by detact		Part II. Other significant conditions	contributing to death be	ut not resulting in	n the ur	nderlying cause give	en in Parl	t I.	23e. Did	tobacco	use contribute to	the cause of	death2
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Y Y	has has	Completed								24a. Was auto perto 1 ☐ Yes		prior to death?	topsy findings completion of	available cause of
Vital	icien: Th certificate rector. pag	Be (25. Was case referred to medical examiner?					26. Plac	ce of Death (
0		ျှ	1 □ Yes 2 □ 106	Hospital: 1 Inpatie		itpatien	t 3 DOA Oth	er: 4 👿	Nursing Home	5 🗆 Resi	dence	6 ☐Other (Spe	cify)	
uoi	anding P lath. pr: After t	atlon:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation		Year) 28b. 1	Time of njury	28c. Injun Work M 1 🔲	yat k? Yes 2.[d. Describe	how inj	ury occurred		
DIVISION	el or Atte s after de il Directo	Certification:	3 Suicide 6 Could not to determined		ury - At home, fa	rm, stre	eet, lactory, office		281	Location (City or To	Street a wn, Sta	and Number or Ru te)	ıral Route Nur	nber,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical (29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination an	d/or inv	occurred at the timestigation, in my of	ne, date a pinion, de	and place, and eath occurred	d due to the at the time,	cause(: date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1- ::	- 10		29c. License)edmin	10-		29d. D	ate signed (Monti	n, Day, Year)	
			12./2low	NZ CILI	W		Y	4(1)	1142	4		18-73	205	
	, (~		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, i	Print)					000		·
	10		BETSY Blank	CKNP 6	200R1	de	Cly Ave	#2	231 A	mna.	001	is, non	. 2140	0/
	Sta	_	31. Date liled (Month, Day, Year)	32 Registra	r's Signature	1 horse	region !			7			, ,	-
	Registr	ar	AUG 2 5 2	005 13 211	and stars of	C. P.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 0.0 F

	1	For State Registrar	state of Maryland	Cer	tificate of E	Death		Reg. No.	105	21111
Physici	an	Decedent's Name (First, Middle, Last) EVELYN			MENDELSON		2. Date of Dea Month AUGUST		200წ	3. Time of Death 7:36 P M
/Medic Examin		4a. Facility Name (If not institution, give stre 6317 PARK HEIGHTS		111	4b. City, Town, or BALTIMO			4c. Co	unty of Death	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month Da 03/22/1	930		place (State or Foreign intry) MD
yland sow		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Lo	cation					10d. Inside City Limits
Ba-f sk	Director	MD N/A	BALT	IMOR	10f. Zip Code			10g Citizen	of What Cou	1 ∑ Yes 2 □ No
s with the		10e. Street and Number 6317 PARK HEIGHTS	AVE. UNIT #11	1	21215			•	U.S.A.	andy:
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "neturel", or Items 23e or 28e-f show event, the Medical Examination rollings at	by Funeral		Was Decedent Ever in U.S. Armed Forces? 1Yes _ 2 \overline{\Delta} No If Yes, Give Year or Dates:	13.	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Amer Black, White ecify: W	
hin 72 hou e. an "neture Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ion	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation luring most of work)	ing		of Business/l	
filed with Hygiene other than		17. Father's Name (First, Middle, Last)	2	HOME	MAKER	18. Mother's Nam	e (First, Middle,	L	N HOME	
thould be find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Mental Find Mental F	o Be	MEYER		BERI	DINSKY	SARAH			JE	FF
and and is m	-	19a. Informant's Name/Relationship (Type	· · ·		ng Address (Street a					
1 and Healt tem 2		FRANK MENDELSON / 20a. Method of Disposition 1X Burial 2 Cremation 3 Rer	cem	e of Dispo	7 PARK HE esition (Name of matory or other plac NESH		Date		ion - City or l	
permit. Pages Department of I Important: If it eny injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	BETT	I ISR	AEL 2. Name and Addres	U8/24 ss of Facility SOI		SON &	BROS.,	INC.
8288	11	Rotal Fatautha disease or complian	tions that caused the death	Do not en	900 REIST	ERSTOWN I	OAD - F	PIKESV	ILLE,	Approximate
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen	nce of):	ge Con	OPD orong	ohst	Luci	fue	Interval Between Onset and Death
ificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
ath cert ttendin or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	b. If yes, outcome of pregnance 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	leath 3[□Ectopic pregnancy			230	d. Date of deli Month	very Day Year
uires that the dea signed by the a lid be detached f	by	Part II. Other significant conditions control	ibuting to death but not resulti	ing in the u	ınderlying cause gıv	en in Part I.		tobacco use Yes 2□I		the cause of death?
sician: The law require certificate has been si irector, page 2 should l	Completed						24a. Was auto perfe 1 \(\text{Yes}		24b. Were au prior to death?	topsy findings availab completion of cause of
	Be	25. Was case referred to medical examiner?	spital:		Oth	26. Place of Dea				
ng Phy fter this ineral d	ion: To	27. Manna of Death 1 Natural 5 Pending	1 Inpatient 2 El	R/Outpatie 28b. Time o Injury	of 28c. Injur	4 Nursing n	ome 5 Tes 28d. Describe			cify)
l or Attending after death. Director: After	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office			(Street and I wn, State)	Number or Ru	ural Route Number,
Hospite 24 hours Funerel tely filled	Medical Co	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine one)	cian: To the best of my knowler: On the basis of examination and manner stated.	ledge, dea on and/or in	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time.	cause(s) ar , date and p	nd manner as lace, and due	stated. to the cause(s)
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X		(Jan Ma	luen M	<u>8</u>	DOC	05189	6	8/ :	22/05	
10		Local MALINON	apleted cause of death (Item 2) 32. Registrar's Signatu	0(0	Print) Cuerp	TRO	BACT	MOP	E WY	3 21208
S: Regis	tate trar	31. Date filed (Month, Day, Year) AUG 2 5 2005	32. Hegistrar's Signatu	Ana	dis					

			1 - For State Registrar	State of Ma	aryland	/ Depa	artment of rtificate o	Health f Deat	and M h		gier)5	27778
	Physici /Medio			LICE 1	NEE	S				2. Date of De Month AUG-	200	<u> </u>	Year 05	3. Time of Death 10:45 AM
	Examir	er	4a. Facility Name (If not institution, give HARBOR #	OSPITA	e (In yrs. las	st hirthday)	4b. City, Town	LTII	n of Death No R er 24 Hrs.	8. Date of Bir		County N		place (State or Foreign
	Funeral Director		175 20 3821 10 Usual Residence of Decedent	M 2 1 F	78	Yrs.	Months Day			(Month, Da	ıy, Yəar)	926	Cou	nsylvania
	the Maryla 28a-f show	Director	Maryland N/A 10e. Street and Number			Town or Lo	ore				10.00			1 ØYes 2 No
	sath with	eral Dir	4205 Morrison (Court		140		1226				U.S		
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Modeal Examiner must be multiled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Ci 1 ☐ Yes 2 🖾 N	uban, Mexid	an, Puerto I	ecity Yes of No Rican, etc.))-	Blac	e - Ameno ck, White, v: Whi	
Maryland 21215-0036	within 72 h ene. than "natu ne Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		(Give life.	dent's Usual Occ kind of work dor DO NOT use reti emaker	ne during m	ost of workii	ng	16b. K		usiness/fn Home	ŕ
/land 2	should be filed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Andrey	v Vance				18. Mo		(First, Middle, e Varme		Suman	70)	
Mar	1 and 2 sho Health and em 27 is m thar treum		19a. Informant's Name/Relationship (Ty Carl Nees / Husl 20a. Method of Disposition		20h Pla	4205	Morriso	n Cou	rt I	Baltimo	re,	Mar	yland	•
altimore,	permit. Pages Department of I Important: If ite any Injury or of		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Juneral Service License			view	sition (Name of matory or other p Cremato: 2. Name and Ado	ry	8/26/	2005	Ba1	timo	ore,	Maryland e, P.A.
m T	a my		23a. Part1. Enter the disease, or compli	cations that caused	the death.				Highwa	y Bal	timo			land 21225
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	14.000	TAT	IC_A	-DENO	CAR	CINON	nA				Interval Between Onset and Death Months
	Examiner and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):	INAL	BLE	ED11	JG				Two DAYS
8760,	icate be executed physician and s the burial-transit	dical Ex	L.	Due to (or as a	conseque	nce of):								
.O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pregnar Other (specify)					23d. Dat Moi	e of delive	ory Day Year
ds, P	uires that signed b lld be deta	by	Part II. Other significant conditions cor					given in Par	t J.	23e. Did to		use contr		e cause of death?
Records,	The taw requires that the cate has been signed by the page 2 should be detache	Completed	PERICARG	NAL E	PPU	1510	N						teath?	psy findings available inpletion of cause of
Vita	yeicien: Th is certificate director, pag	To Be C	25. Was case referred to medical examiner?	ospital:	nt 2 🗆 E	VOutpatien	t 3 DOA)ther		(Check only one 5 Resid	ne)			
Division of	ling Ph After th uneral	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 21	8b. Time of Injury	28c. In		2	8d. Describe h				7
N N	lospital or Attand hours after death unerel Director: sly filled in by the f		3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify)					City or Tow	m, State)		l Route Number,
	To the Hosp within 24 hor To the Fune completely fi	edical	29a. Certifier 1 ← Certifying Phys (Check only one)	icien: To the best of er: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the restigation, in my	time, date a popinion, de	and place, a eath occurre	nd due to the o	date and	and ma d place, a	nner as st and due to	ated. the cause(s)
	To t	M	29b. Signature and title of certifier	lahalla	h.			1437	_	A		_		2009
	6		30. Name and address of person who co	mpleted cause of de	ath (Item 2	3a) (Type,	Print)	ANAVÝ	RRT	REET,	RA	אתנו	IORE	MARYLAM

DHMH 17 Rev 1/2001

Registrar

1		/Medic Examin	al er	
	La Jaggia	Funeral Director		
AUGUST 23, 2005 0:20 P.m.	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, It a Madical Examination into the mailing at once.	To Be Completed by Funeral Director	
ARNO NEHRLING	Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit in property.	Medical Certification: To Be Completed by Physician/Medical Examiner	

1 - State Registrar		Ce	rtificate of		R	eg. No.		3. Time of	Death
Decedent's Name (First, Middle, Last)					2. Date of Dear Month	Day	Year		
	ehrling,	Jr.	T	dessite (Dest		23, 200		6:20	РМ
4a. Facility Name (If not institution, give str			1	r Location of Death	1	,		more	
Stella Maris Hospic		(In one least high day	Timonia If Under 1 Year	IM If Under 24 Hrs.	8. Date of Birth			nace (State o	r Foreign
014-22-5284	/. Age	(In yrs. last birthday 77 Yrs.	Months Days	Hours Min.	March 5,	, Year)	IN	ntry)	
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside Ci	ty Limits
								1 🗌 Yes	2 ∑ No
MD Baltim	ore	Timo	10f, Zip Code		1	I0g. Citizen of W	hat Cou	ntry?	
2525 Pot Spring Rd	#S719		210	าว			USA	,	
	2. Was Decedent E	ver in U.S. 13			pecify Yes or No-			can Indian,	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ N tf Yes, Give 50 Year or Dates:	0	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛱 No	an, Mexican, Puert Specify:	o Rican, etc.)		k, White, : Whi		
			edent's Usual Occup	nation		16b. Kind of Bu	siness/In	ndustry	
15. Decedent's Educa (Specify only highest grade	completed)	(Giv	e kind of work done DO NOT use retire	during most of wor	rking	100.11.10		,	
Elementary/Secondary (0-12)	College (1-4or 5-	+)	Assist Tr			Chem	ica1		
17. Father's Name (First, Middle, Last)	J.				ne (First, Middle,				
Arno Herbert Nehr	ling. Sr			Irene	Dahlber	g			
19a. Informant's Name/Relationship (Typ			ling Address (Street				State, Zip	c Code)	
Mary Mudd Nehrling/			5 Pot Spr						
20a. Method of Disposition	MITE	20h Place of Dist	nosition (Name of		Date	20c. Location -			
1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	moval from State	Mt. Com	amatory or other pla	∞) ¦Augu	ost 26,	۵1۵	vand	ria, V	ΤΔ
4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septical idenses	a .	Cremato							
46)	chael J.	Flagle	22. Name and Addre Lemmon Fur 10 W. Pad	neral Hom	ne of Dul	aney Va	$\frac{11ey}{v1an}$, Inc.	3
23a. Pat 1 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	SMALL C	the death. Do not e e. ELL RENAL a consequence of):		ng, such as cardiad	c or respiratory an	rest,		Approximat Interval Bet Onset and	ween
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	B Ectopic pregnanc C Other (specify)	у		23d. Dai Mo	e of deliv		Year
Part II. Other significant conditions con-	tributing to death b	ut not resulting in the	underlying cause g	ven in Part I.	23e. Did to	obacco use cont	nbute to	the cause of	death?
					101	res 2□No	3 🗆 Pro	bably 4X	Unknown
					24a. Was autop perfo 1 🗆 Yes	rm <u>ed</u> ?	Were autorior to death?	opsy findings ompletion of a	available
25. Was case referred to medical examiner?	ia-lu				ath (Check only o				
1 ☐ Yes 2 📆 No 27. Manner of Death	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		of 28c. Inju	iry at ork?	Home 5 Resid	dence 6XIOth		ity) HOSP	ICE
1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide determined		ury - At home, farm, c. (Specify)]Yes 2 □No	28f. Location (S City or Tox	Street and Numb	er or Rui	ral Route Nur	nber,
	ician: To the best	of my knowledge, de	eath occurred at the	me, date and plac	e, and due to the	cause(s) and ma	nner as	stated.	
29a. Certifier 1 Certifying Phys (Check only one)	er: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occ	urred at the time,	date and place,	and due	to the cause(s)
29b. Signature and title of certifier			29c. Licer	se number	_	29d. Date signe	/		
30. Name and address of person who co	mpleted cause of c	leath (Item 23a) (Tur	oe. Print)	121-3		-/-	1		
DR. TARIO MAHMOOL	_	ULANEY VA		TTMONTUM	, MD 210	93			

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 5 2005

ARNO NEHRLING

32. Registrar's Signature

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Physici		1. Decedent's Name (First, Middle, Last	raine Theres			mouto	0, 2	outri		2. Date of I Month		Day	Year	3. Time of D	
/Medic Examin		4a. Facility Name (If not institution, give SINA HOSPI	street and number) TAL OF PAL	TIMOR	re .	4b. City, To BAL	TIM	WR6	- CI	TY		4c. County	of Death		
Funeral Director		5. Social Security Number 210–22–8001 6. Se	× 7. Age (In	yrs. last birt		If Under 1 Months I	Year Days	If Under Hours	24 Hrs. Min.	8. Date of I (Month, Jan.	Birth Day, Ye 19,	a′) 1931	9. Birthi Coul Pen	place (State or ntry) nsylvan	Foreign lia
ne Maryland 8e-f show	ector	10a. State 10b. County Maryland Balt	imore	City, Towr	n or Loca			-						0d. Inside City	
th with th	al Dire	10e. Street and Number 707 Hickory Lot	Road			10f. Zip C	212	86				Citizen of ited		· ·	
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. It health and service other than "natural", or Itams 23a or 28e-f show other traumatic avant, the Medical Exactiver must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U.S.		as Deceder Yes, specify		anic Ori Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or Rican, etc.)	No-		ce - Americ ck, White,		
within 72 hor ene. then "netura he Medical E	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)		(Give ki life. DC	int's Usual (ind of work O NOT use	done du retired)	ring mos	t of worki	ing		. Kind of B		,	
2 should be filed within and Mental Hygiene. Is marked other than aumatic avant, It a Me	BeCc	12 17. Father's Name (First, Middle, Last)	6			tered	1		er's Name	First, Midd		Healt den Suman		re	
should bud Ment	T _O	Joseph 19a. Informant's Name/Relationship (T)		ysack					lia	ıl Route Nun		len		ludak	
ing physician and ing permit Pages 1 and 1 permit Pages 1 and 1 permit Pages 1 and 1 permit p	Medical Examiner	IF FEMALE:	Dulaney lications that caused the ne cause on each line. SEPTO Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	Brian death. Don Significant of the sequence	n T ²² . 1 2(not enter	Chiston Chisto	Address no Im Pad of dying,	of Facility Onia such as	eral Roa	Servi d, Tin	ces	of D	ulane	Maryl Py Vall 1093 Approximate Interval Betwoonset and Do	ey,
That the death certificated by the attending placed by the attending placed for use as the	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death		Ectopic preg Other (spec					-		te of delive onth	ery Day Ye	ar
v requires Iha been signed I should be det	by	Part II. Other significant conditions co				erlying cau		in Part I						ne cause of de ably 4	-
aician: The law requ certificate has been irector, page 2 shouli	e Completed	CHRONIC RES		1 F 1SEA		LUR				1 Tyes	topsy rformed 2 🛂	?/	Were auto prior to co death? 1 Yes	psy findings av mpletion of cau	variable use of
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To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	oecify)						City or 1	Fown, St	ate)		l Route Numbe	er,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical	29a. Certifier 1 **Certifying Phy (Check only one) 1 **Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge mination and	dor inve	occurred at estigation, in	the time my opir	, date an nion, dea	d place, ath occurr	and due to the ed at the tim	e, date	e(s) and mand place,	anner as s and due to	tated. the cause(s)	
To the vithin To the comp	Me	29b. Signature and title of certifier			-	29c. l	License r	number			29d.	Date signe	d (Month,	Day, Year)	
		30. Name and address of person who c	V-B-B-S	(Item 22a) /	(Type P	(K	ts	-00	U		AL	16 US	TQ	1,200	75
(p Sta	te.	DARSHAWA 31. Date filed (Month, Day, Year)	M-B-B-S completed cause of death PUROULT 32 registrar's S	ignature	B 1	35.	SIM	VAI	F	10591	TAI	- 0,	FB	ALTIM	ORE
Registr		AUG 2 5 20	05 les sur	K ,	Spa										

State of Maryland / Department of Health and Mental Hydiedd U 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:00P M EDNA PRIGG 08 18 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD MARINER HEALTH OF FOREST HILL FOREST HILL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) NOV 11 192 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M **XX**F Days Yrs. 1921 MARYLAND 83 Director 220-24-4522 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show treumatic event, the Medical Examiner must be notified at 1 Yes 3 No Director HARFORD CO FOREST HILL MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or Items 23e 21050 U.S.A. 109 Rockspring Church Rd. Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 Is marked other then "naturel", or item any injury or other treumatic event, the Medical Exaturinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: BLACK ğ 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEKEEPER 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DASIY LEE DORSEY ALLEN PRESBERRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 Rockspring Church Rd., Forest Hill, Md, 21050 Dolores H. Presbury/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State BERKLEY CEMETERY 08-24-05 DARLINGTON, MARYLAND ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer Vice Vice 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sta **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of). P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea esn 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 20 No 1 Yes SQ No 1 Tyes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After t Certification; Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Day 032295 AN 7 UST 17 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 21014 31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, perMe, G846,8;30;05,11

27722

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other treumatic event, Ite Medical Examinational pencilitied at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 = For State Registrar	Ciaio or ivid	ary tarra 7		tificate of				Reg. No.	100	21102
n	1. Decedent's Name (First, Middle, Last Dionne Reyes		es-Broo	ks-				2. Date of Dea Month ugust	Day	2005	3. Time of Death 12:05 A M
r	4a. Facility Name (If not institution, give 2900 Tucker Road	street and number)			4b. City, Town, or Fort Wa		ton		Pr	unty of Death ince Ge	
	013-66-0275	x 7. Ag. □M 2X F	e (In yrs. last b	vrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day July 1	y, Year) 5, 19	9. Birthr Cour Inc	olace (State or Foreign ntry) liana
tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City, To							1	1 Od. Inside City Limits 1 ☐ Yes 2 XNo
II DILE	10e. Street and Number 13222 Brandywine	Road			10f. Zip Code 20613				10g. Citizer	of What Cour	ntry?
lo Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 △ I If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Orig in, Mexican, Specify:	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Americ Black, White, pecify: B1a	etc.
mpieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give life. l	dent's Usual Occup kind of work done DO NOT use retired al Assist	during most f)	of working	9		of Business/In	dustry
Re Co	17. Father's Name (First, Middle, Last)	3		106.	1130130	18. Mother	_	(First, Middle,			
0	Leo Reyes 19a. Informant's Name/Relationship (7) Darlene Knight	ype, Print) (Mother)			ng Address <i>(Street</i>	and Numbe	r or Rural				Code)
	20a. Method of Disposition 1 Disposition 1 Donation 5 Other (Specify,	Removal from State	20b. Place cemet	of Dispo	sition (Name of natory or other place	ee)	8/19	te	20c. Loca	tion - City or To intree,	
	21. Signature of Funeral Service Licens	-	~		Name and Addre Cartwrig 419 N. M	ss of Facility ht Fur	neral	Home			
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	the death. Do	7P	er the mode of dyin	g, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
edical Examiner	Sequentially list conditions, if any, leading to intrindiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	,			230	d. Date of delive Month	ery Day Year
ed by Pn	Part II. Other significant conditions co	ontributing to death b	ut not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did to	0		he cause of death?
Completed by Physician/N		NAME VII				No. of the last of					opsy findings available impletion of cause of 2 No
lo De	TIX 168 2 NO	Hospital: 1 ☐ Inpatie				er: 4 □ Nur	rsing Hom		dence 6		wat scene
Medical Certification; 10	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	0.11	y Year)	Time of Injury	28c. Injur Wor M 1 — et, factory, office	k?	40 K	ad. Describe h	Street and N	autoc	al Route Number,
edical	(Check only 2 Medical Exam	ysician: To the best liner: On the basis o and manner st	f examination a	ge, death and/or in	vestigation, in my o	pinion, deat	d place, ar	at the time,	date and pl	ace, and due to	the cause(s)
2	29b. Signature and title of certifier	w			O.C.			· •		t 11, 2	

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 5 2005

Cockerno

. Figistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie (2) 05 27

		1	_ Stata	State of Maryland	d / Depa <i>Cer</i>	rtment of F	lealth and I Death		ie 2e() () 5 eg. No.	27183
			Registrar 1. Decedent's Name (First, Middle, Last)			imouto or i	- Journ	2. Date of Deat	h	3. Time of Death
	ysicia		Irish Roslyn Rie	ddick				Month	23 200	
	ledic amin	_	4a. Facility Name (If not institution, give st.			4b. City, Town, o	r Location of Death		4c. County of De	
		·.	FRANKLIA SOUL	ce Hospita	1	K050	DALE	, .	Raltir	2000
Fun	eral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
Direc	ctor		245-84-9350	M 2XIF 54	Yrs.			March 30), 1951 Ma	
and		-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
Maryi f eho	a pa	ō	Maryland	Ra1	timore		•	•		1∭Yes 2☐No
the 28a	E E	Director	10e. Street and Number	Dai	CIMOLE	10f. Zip Code		10	0g. Citizen of What C	Country?
with with	12	<u></u>	8428 Avery Road			21237			U.S.A.	
deat	20	Funeral		2. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Arr Black, Wh	
o affer o	Ē	Y Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		☐ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify	
hours ural;	Ex	d by	3 Widowed 4 Divorced	Year or Dates:		ent's Usual Occup	ation		F	Black
n 72	adica	Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Give I	kind of work done OO NOT use retired	during most of wor d)	rking	16b. Kind of Busines	sindustry
withi iene. than	N B M	E	Elementary/Secondary (0-12)	College (1-4or 5+)		ms Audit			State of	Marvland
a filed of their other	/ant.	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M		
Jid ba Menta rikad	tic ev	To B	Howard Cartwright				Judia	Forbes		
and hard	anma		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Number,	, City or Town, State,	Zip Code)
and and a	er tra		Kenneth Riddick (_			., Balti	more, MD		
Dattilliore, Intal yiello 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Itams 23a or 28a-f ehow	or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re		lace of Dispos emetery, cren	sition (Name of natory or other plac	ce) 8/	Date 27/05	20c. Location - City of	
mit. Pages partment of portant: If it	jury		' 4 □ Donation 5 □ Other (Specify)	Forb		stead Ce	metery		Camden, N	C
Dermit Depar	any in		21. Signature of Funeral Service Licenser	97/	22	Walson F	uneral H	ome, Inc.	•	
			23a, Part1. Enter the disease, or complic	eations that caused the death	Do not ente				h City, N	C 27909 Approximate
3.5	-1		shock, or heart failure. List only one	cause on each line.				W		Interval Between Onset and Death
Pnysic /Med			disease or condition resulting in death)	Due to (or as a consequ	t-1C	EZOPY	rageri	(Arc	WOMA	
Exam				Due to (or as a consequ	derice or,	₹7.	,			
		Jer	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uanea of):					
cutad	ransit	Examiner	Cause (Disease or injury that initiated events c.							
cate ba executad	urial-I	EX	resulting in death) Last	Due to (or as a consequ	uence of):					
orou, ate ba e. shysician	the b	dical	d.							
artific Jing p	as as	a ·	IF FEMALE:	3c. If yes, outcome of pregnar	nov				004.000.44	-0
DUX sath car attendin	for us	lan	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	Day Year
i he d	ched	Physician/M	1 □ Yes 2 🐼 No 9 □ Unknown	9□ Unknown	34					
The law requires that the death cardifute has been signad by the attending p	deta	by Pr	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ecords, law requires t as been signs	nd be	q p						1 □ Ye	as 2⊡No 3⊡I	Probably 4 Xunknown
aw re	sho	ompleted						24a. Was a	n 24b. Were	autopsy findings available completion of cause of
VITAL MEC eician: The law scertificate has t	page	Шо						autops perform	ned? death?	es 2 No
- 0	otor, p	e C	25. Was case referred to medical				26. Place of Dea	ath (Check only on		
OI VILA Phyeician: this certific	direc	To B	examiner? 1 ☐ Yes 2X No	ospital: 1 🔀 Inpatient 2 🗆 1	ER/Outpatien	1 3 JUCA		fome 5 ☐ Reside	ence 6 Other (Sp	ecify)
	ınera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	y at rk?	28d. Describe ho	ow injury occurred	
SIO tendi leath. tor: A	the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	Ogi Lacation (Ca		Dural Bauta Musabas
JIVISION I or Attending after death. Director: Afte	in by	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, tarm, str	eet, factory, office		City or Town	reet and Number or i n, State)	nurai moute Number,
spital ours a	filled		29a. Certifier 1 X Certifying Phys	ician: To the best of my know	wledge, death	occurred at the ti	me, date and place	e, and due to the ca	ause(s) and manner	as stated.
e Hos	letely	edical	(Check only 2 Medical Examin	er: On the basis of examinat and manner stated.	tion and/or inv	vestigation, in my o	pinion, death occu	irred at the time, da	ate and place, and d	ue to the cause(s)
LIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in by	Me	29b. Signature and title of certifier	-		29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
			1 cy	7 M	(.D.	D	00632	2/6	August 2	23, 2005
	B		30. Name and address of person who con	meleted cause of death (Item	23a) (Type,	Print)	^	12 / '		
			JING TONG MO	mpleted cause of death (Item 32. Regularia's Signal	cklin	Spinse	Drive	120141b	nore md	21237
D,	Sta gistr		31. Date filed (Month, Day, Vear) AUG 2 5 2	2005 Marine	H	Scarles				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and	Mental Hygie Re() () 5

			1 - State Registrar			Cer	tificate of i	Death			Reg. No.				
Topic Control	78 20 12	-	1. Decedent's Name (First, Middle,	Last)	-					2. Date of De			3.	Time of Death	
	Physici		EDWARD ANTHO	NY RIGGIO						AUGUST	23	, 2005	1	11:43 AM	
	/Medic		4a. Facility Name (If not institution,		r)		4b. City, Town, or	r Location o	of Death			County of Dea			-
	Examir	er			.,				or Double						
	No.	^O le	GILCHRIST CENTE		Age (In yrs. last birtho	daul	TOWS	If Under	24 Hrs	9 Date of Ric		BALTIMO		(State or Foreign	_
	- Funeral			12 M 2 F	V-	7,	Months Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	C	ountry)		
	Director		166-30-6978		68 T	J.				5/20/	1937	PEN	NSYL	JVANIA	_
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Loc	cation						10d. Ir	nside City Limits	_
	ehow	7		10DE										☐Yes 2X No	
	Ne N 8a-1	ecte	MD BALTIM	ORE	TOWSO	IV .	T								_
	ith it	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What C	ountry?		
	238	Ta .	1617 COTTAGE L	ANE			21286					SA			
	ep .	Ine	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Whi		idian,	
9	afte or It	F	1 Never Married 2 Marrie	d 1 □Yes 2 □ If Yes, Give	X /10		☐Yes 2XNo	Specify:				Specify: T.		_	
5-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-1 ehow Iteal Examente mount be notified at	d by	3 Widowed 4 Divorced	Year or Dates	:							W	HITE	<u> </u>	
5-	72 h natu	Completed	15. Decedent's (Specify only highest		(0	Give A	ent's Usual Occup kind of work done	durina mos	t of worki	ng	16b. Ki	ind of Business	/Industry	У	
2	within ene. then *	npi	Elementary/Secondary (0-12)	College (1-4o	r 5+)	ife. D	OO NOT use retired	1)							
2	filed within Hygiene.	Son		9 YEARS	Pl	ROF	FESSOR				ED	UCATION			
5	be file id oth sveni	To Be	17. Father's Name (First, Middle, La	ast)				18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)			
<u>a</u>	iould be Mental narked o		JOSEPH RIGGIO					PAUI	LINE	COLLUR	A				
Maryland	and N		19a. Informant's Name/Relationshi	p (Type, Print)	19b. N	Mailing	g Address (Street	and Numbe	er or Rura	l Route Numb	er, City o	r Town, State,	Zip Code	е)	
	nd 2 alth a 27 is		TONA ANN RIGGIC	/WTFE	10	617	7 COTTAGE	LANE	\mathbf{E} \mathbf{TC}	WSON. I	MD 2	21286			
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Maryla if of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehov or other traumatic event, the Wedical Exameration modified at		20a. Method of Disposition		20b. Place of D	ispos				ate	20c. Lo	ocation - City o	Town, S	State	_
20	ages ant of I it: If It y or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	_	(0)		EMATORY,		8/2/	12005	САТУ	ONICUTII	E 10	4D	
Ē	permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Li		MEIRO		. Name and Addre					ONSVILL			_
Ba	Depermine Depermine Important Inches		1 Lac VI	1) /4			521 LOCH						поме 286	, P.A.	
	%		23a. Part1. Enter the disease, or c	omplications that save	ad Maddaath Da aa	_					<u>.</u>	וא עוו		roximate	_
* **			shock, or heart failure. List of	nly one cause on each	line./				i		11651,		Inte	rval Between et and Death	
	Physician .	Ÿ. I	Immediate Cause (Final disease or condition	= mul	uti-ova	100	1 575+	en -	tai	We				eers	
	/Medical		resulting in death)	Due to (or a	as a consequence of	:	1 0					•			
	Examiner		Sequentially list conditions	b. PS	edom	n	or pre	2016-	nia				w	elexs	
	p =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of)):	•								
	cute nd rans	anl	Cause (Disease or injury that initiated events	с											
o,	an a Irial-1		resulting in death) Last	Due to (or a	as a consequence of)):									
68760	ertificate be executed ding physician and se as the burial-transit	Medical	3	d											
68	tifica ig ph as th	led													_
ŏ	Se di se		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		۰.	I					23d. Date of de	livery		
Bo	death a atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	2 ☐ Fetal death at time of death		Ect <i>o</i> pic pregnancy Other (specify)					Month	h Day Year		
P.0	the ache	Physician	9 □ Unknown	9□ Unknown											
	than hed b	by Р	Part II. Other significant condition	s contributing to death	but not resulting in the	he un	derlying cause giv	en in Part I		23e. Did t	obacco u	use contribute t	o the car	use of death?	
sp.	uires sign	D D	mitralur	we ver	sair,	1 the pertension 10					☐ Yes 2 0 3 ☐ Probably 4 ☐ Unknown				
The law requires that the dead of the dead of the dead of the attending to the dead of the						242 \					Was an 24b. Were autopsy findings available			indings available	
The state of the s								auto	DSY	complet	ion of cause of				
<u></u>	r: Tr icate r, pa									1 ☐ Yes				No	_
of Vital	Physician: rthis certifica ral director, i	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one) oatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) OSpice							_				
to	Phys this al dir	10	1 Yes 2 No		itient 2 ER/Outp		t 3 DOA	4 N				6 Other (Spe	ocity,	ospice	_
Ē	ing f	on	1 XiNatural 5 ☐ Pending		njury 28b. Tin Day Year) Inju		28c. Injur Wor			28d. Describe	now injur	y occurred		•	
sic	Attending ir death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	ot be				Yes 2							_
Division	or At after d Direct in by	Ħ	4 Homicide determin	28e, Place of	Injury - At home, farm etc. <i>(Specify)</i>	n, stre	eet, factory, office			281. Location (City or To	Street an wn, State	id Number or F)	ural Rou	ite Number,	
	ital curs at curs at Direction	ပိ													
	losp t hou une aly fil	cai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be- xaminer: On the basis	st of my knowledge, of examination and/	death	occurred at the tir	ne, date ar	nd place,	and due to the	cause(s)	and manner a	s stated.	rause(s)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Certification:	one)	and manner	stated.					-					
	To To	2	29b. Signature and title of certifier	in .1	0		29c. Licens	e number			29d Dal	te signed (Mon			
	. 1		1 -11 m	Thony K	ily,	1	りりみ	1900	2		MU	igus!	13	2005	
-	12		30. Name and address of person w									1			
	100		N. ANTHONY RILEY		CHARLES S	ST.	TOWSON,	MD	2120	4					
	Sta	ite	31. Date filed (Month, Day, Year) AUG 2 5 20	32. Regis	strar's Signature										
3	Regist	ar	400 6 9 ZU	US Region	. D. Son	200	2 3								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 2005

			1 - State Registrar		Certificate of L	Death	Re	g. No.			
	Dhuaisi		1. Decedent's Name (First, Middle, Las	it)		2	. Date of Death Month	Day Year	3. Time of Death		
	Physicia /Medic		Gunther William	Reimann		A	ugust	24, 2005	11:00 A ^M		
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or	Location of Death		4c. County of Death			
			1817 Palo Circl		Arbutus		D (Dist.	Baltime			
	Funeral Director		5. Social Security Number 219-12-6921 Usual Residence of Decedent	ex 7. Age (In yrs. last bi	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, 0 / 1 4 / 1	Year) Cou	place (State or Foreign ntry) nany		
	land		10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits		
	Mary f sho	Ď	Maryland Baltimor	re Arbu	tus				1 ☐ Yes 2 XNo		
	28a	rec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?		
	h with	Funeral Director	1817 Palo Circle		21227		U	nited State	es		
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi	ispanic Origin? (Speci in, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ameri Black, White,			
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other traumetic event, I've Medical Examinational be notified along.	by	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 X No	Specify:			ite		
15	n 72 h "netu	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of working	1	6b. Kind of Business/Ir	dustry		
12	withi	ф	Elementary/Secondary (0-12)	College (1-4or 5+)	chanical eng		6	lectrical t	estina		
D N	Hiled Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)		CHAILCAL CHY	18. Mother's Name (
Maryland	uld be fenta rked lic ev	To B	William Heinrich F	≀Eimann	þ	Emilie Sch	lautz				
ary	s ma		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street a	and Number or Rural I	Route Number,	City or Town, State, Zip	Code)		
Ž	and 2 salth a n 27 I er tre		Clay M. Carroll -		817 Palo Circ	cle, Arbut	us, Mar	yland 21227	7		
Baltimore,	of He fitem r oth		20a. Method of Disposition 1 XBurial 2 Cremation 3	comete	of Disposition (Name of ery, crematory or other plac	Dat	9 2	0c. Location - City or To	own, State		
<u>Ĕ</u>	Pag ment ent: I ury o		'4 □Donation 5 □ Other (Specify	Loudor	n Park Cemete						
3a It	Departi Departi Import any inj once.		21. Signatur Funeral Service Licer	1500	22. Name and Addres	ss of Facility Hubb	ard Fun	eral Home,	Inc.		
_	70 E 29		Mury.	ZUW	4107 Wilker	ns Avenue,	Baltim	ore, Maryla			
	Priysician		23a. Part1. Enter the disease, of com shock, or heart failure. List only	one cause on each line.			espiratory arre	st,	Approximate Interval Between Onset and Death		
			Immediate Cause (Final disease or condition resulting in death)	a. LUNG	CANCER			/	OMONTHS		
	/Medical Examiner			Due to (or as a consequent	of):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence	e of):						
68760,	ate be nysicia ne bu	Medical	(. d					-		
39 3	ntifica ing ph e as tl	Med	IF FEMALE:								
Вох	ath ce ttend or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat				23d. Date of deliv Month	ery Day Year		
<u>o</u> .	es that the death cer igned by the attendin be detached for use	by Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)				,		
0	that II	Ph	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?		
Vital Records,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u		,		, , ,		1 Yes	s 2 No 3 Prol	pably 4 Unknown		
202	w requir been si should	lete					24a. Was an	24b Were auto	nsy findings available		
Re	The fav	Completed				autopsy perform	prior to completion of cause of death?				
Ta Ta		a)	25. Was case referred to medical			26. Place of Death (Check only one		2 L No		
	Physicien: this certificatal director, i	o B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient 3 DOA Othe	0.5		nce 6 Other (Specia	(v)		
0	g Phy er thi	n: T	27. Manner of Ceath 28a. Date of Injury 28b. Time of 28c. Injury at 28d. escribe how injury occurred Work?								
jo	andin lath. or: Aft	atlo	1 Natural 5 Pending investigation	n		Yes 2 □ No					
Division of	or Atter de lirecte	Certification:	3 Suicide 6 Could not b 4 Homicide determined		farm, street, factory, office	28	 Location (Street) City or Town, 	eet and Number or Run State)	al Route Number,		
Ω	urs af urs af ral D					<u> </u>					
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or	Medical	29a. Certifier (Check only one) Certifying Pr (Check only one)	nysician: To the best of my knowledgeniner: On the basis of examination a and manner stated.	ge, death occurred at the tim und/or investigation, in my of	ne, date and place, an pinion, death occurred	d due to the car at the time, da	use(s) and manner as s te and place, and due t	tated. the cause(s)		
	ithin ithe	Med	29b. Signature and title of certifie	and manner stated.	29c. License	e number	29	d. Date signed (Month,	Day, Year)		
)	F 3 F 8		141) (M	MID DOCTOI	R D	16354	A	UG 25.	2005		
	A		30. Name and address of person who	completed cause of death (Item 23a)) (Type, Print)	, ,		, , ,	- 0		
6)		EUI COLE	MD STAGN	(Type, Print) (ES 900 C	ATON AVE	BAL	T. MD 2	1229		
	Sta	te	31. Date filed (Month, Day, Year)	32. Figistrar's Signature	Coole				7		

Physician /Medical

Examiner

Funeral

Director

Physician /Medical

JudiTh

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - For State Registrar	State of Maryland /	Certifica	ate of Death			Reg. No.				
Decedent's Name (First, Middle, Last,	Judith Jea	nes Robe	erson		2. Date of Dea	Day	Year 2005	3. Time of Death		
4a. Facility Name (If not institution, give	street and number)	4b. Ci	ty, Town, or Location	of Death		T	y of Death			
FRANKLIN SQUA	RE HOSPILA	4	RosedA	le_		BA	17i)	NORE		
5. Social Security Number 0 6. Sec 228-46-5045	7. Age (III yrs. last	birthday) If Und Month	der 1 Year If Under is Days Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Oct. 1	h y, Year) 1938	COL	place (State or Foreig		
Usual Residence of Decedent	00				Oct. 1	, 1936	Geoi	LYIA		
10a. State 10b. County	10c. City, To	own or Location						10d. Inside City Limit		
Maryland Ba	ltimore		Ed	gemer	е			1 ☐ Yes 2 🔯 N		
10e. Street and Number		10f.	Zip Code			10g. Citizen of	What Cou			
2400 Lincoln Av			212					U.S.A.		
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was De	cedent of Hispanic Or pecify Cuban, Mexica	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	- 14. Ra Bla	ice - Amer ack, White	ican Indian, , etc.		
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	No Specify	:		Speci	ity:	White		
15. Decedent's Edu	ication 16	6a. Decedent's U		. ,		16b. Kind of E	Business/Ir	ndustry		
(Specify only highest grad		(Give kind of life. DO NOT	work done during mos Tuse retired)	st of workir	ng					
8 Years	55115g5 (1 451 51)	Presse	r			Dry	Clear	ners		
17. Father's Name (First, Middle, Last)						Maiden Suma	ime)			
Benjamin F. Jea					P. Shit					
19a. Informant's Name/Relationship (T)			ess (Street and Numb			-				
Lynne Clavin (Daughter) 111 Nelson Road Pikesville, Maryland 21208 20a Method of Disposition (Name of Date 20c. Location - City or Town, State										
1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place)										
Donation 5 Other (Specify) Hilltop Service Corp. 8/25/2005 Towson, Maryland										
21. Sign tre of Funeral Service Licensee 22. Name and Address of Facility Luda-Ruck Funeral Home of Dundalk, Inc.										
,) ,		Luda	Ruck Funer	al Ho	me of I	Dundalk	, Inc			
23a. Part1 Enter the disease, or comp	lications that caused the death. D	7922	Wise Ave.	Dune	dalk, M	laryland	, Inc	222 Approximate		
shock, or heart failure. List only o	lications that caused the death. In the cause on each line.	7922	Wise Ave.	Dune	dalk, M	laryland	, Inc	222		
23a Part Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. COPD	7922 Do not enter the m	Wise Ave.	Dune	dalk, M	laryland	, Inc	222 Approximate Interval Between		
shock, or heart failure. List only of the shock of the sh	lications that caused the death. Description of the cause on each line. a. COPD Due to (or as a consequence of the cause)	7922 Do not enter the m	Wise Ave node of dying, such as	Dune cardiac o	dalk , M r respiratory ar	laryland	, Inc	222 Approximate Interval Between		
shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. COPD	7922 Do not enter the management of the contract of the contra	Wise Ave node of dying, such as	Dune cardiac o	ialk, M r respiratory ar	laryland rest.	, Inc	222 Approximate Interval Between		
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State Registrar

Jacques Conaway, M.D.
31. Date filed (Month, Day, Year) AUG 2 5 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Dr. Baltimore, Maryland
32. Registrar's Signature

21237

State of Maryland / Department of Health and Mental Hygie Pen 15 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 August 16 Eunice P. Roper 5:45 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death Examiner Glen Burnie Anne Arundel Mariner Health Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, Jan. 2, 19 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗑 F 215 12 9804 Yrs. Director 82 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County th and Mental hygiene.
7 is marked other than "natural", or items 23e or 28a-f show traumstic event, the Medical Examinational be notified at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 Queensgate Road 21229 U.S. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes, Give ear or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 2 years State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event page. (not available) Waltz Delia Barry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll Sawyers / Friend 407 Walton Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Louden Park 8/18/2005 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Buneral Service Licer 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** otex disease or condition resulting in death) Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1821 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16 1 126307 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 202 W. MAPLERD, LINTHICUM, RANIS. KARIP

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 5 2005

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

use as the burial-transit

signed by the attending physician and d be detached for use as the burial-tran

should be

director.

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has page 2 certificate

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After

death.

after death

within 24 hours a To the Funerel I

32. Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Betty Louise Sharp 12:35 PM August 19, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2415 Meadow Road Baltimore Dunda1k If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ XF 217-26-1533 75 Yrs Director Jan. 6. 1930 Maryland Usual Residence of Decedent the Maryland 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** the Medical Examiner must be notified at 1 ☐ Yes 2 No **Dundalk** Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 6 21222 United States 2415 Meadow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: ξ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If Item 27 is marked other the
eny Injury or other treument Own Home Home Maker 9 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Henry Stinchecum Pearl Fishpaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 727 Maplehearst Drive Monkton, Maryland 21111 Julie L. Johnson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fairview Church Cem. 8/24/2005 Marlinton, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Avenue Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. po not enler the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Examiner the attending physicien and hed for use as the burial-transit Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2. No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death? 2 \ No 1 Yes 2 No 1 Tyes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) nerel Director: After the 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospitel or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title ol certifie 29d. Date signed (Month, Day, Year) 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

SAW

31. Date filed (Month, Day, Year) AUG 2

HOLABIRD

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730

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2005

32. Register's Signature

State of Maryland / Department of Health and Mental Hygie 20 0 5 Certificate of Death

3. Time of Death

10d. Inside City Limits

Black

Approximate Interval Between Onset and Death

Day

20 No

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 X No

10:55 PM

Physician /Medical Examiner

1 - State Registra

Funeral Director

Show 7 is marked other than "natural", or items 23e or 28e-1 shov traumatic event, the Medical Examinating the modified at filed within 72 hours after death at Hygiene. permit. Pages 1 and 2 should be file.
Department of Health and Mentat Hy, Important: If item Z7 is marked other any injury or other transment.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-transit and attending physician the use as the signed by funeral within 24 hours after death. To the Funerel Director: After

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

To the Hospital or Attending

2. Date of Death Decedent's Name (First, Middle, Last) Month Year 2005 Donnell Cordray Shelton 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George

9. Birthplace (State or Foreign Country) Cheverly Prince George's County Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1**X** M 2□F Year) 367-80-2881 Michigan Usual Residence of Decedent 10c. City, Town or Location 10b. County Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12625 Pavillion Court 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No. 11 / 90 Year or Dates:9 / 16 / 94 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: þ 3 ☐ Widowed 4 ☒ Divorced leted | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) Barber Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alvin Shelton Rosemary E. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Young (Mother) 12625 Pavillion Ct., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/05 4 □ Donation 5 □ Other (Specify) Detroit Memorial Redford Twp., MI 21. Signature of Funeral Service CC0321 22. Name and Address of Facility Pye Funeral Home 17600 Plymouth Road, Detroit. 23a. Part1. Enter the fall shock, or hear fall Immediate Cause (Phal disease or condition resulting in death) lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fure Ust only one cause on each line. Cerebral Edema Due to (or as a consequence of): Massive Hemowhage Due to (or as a consequence of): Massive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No P Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred wested 28b. Time of 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: from vehicle in accident 1 Natural 5 Pending 1 Yes 2 ₹No investigation 29,2005 2 Accident 3 Suicide 0250 28e. Place of Injury - At home, farm, street, factory, office determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

State Registrar

3001 Hospital
31. Date filed (Month, Day, Year) AUG 2 5 2005

29b. Signature and the of certifier

29a. Certifier

Drive 1ev.4 32. Signatura

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

Mp 20785

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D55220

JC 05-05636 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Bruce H. Smith 1- State of Maryland / Department of Health and Mental Hygie 20 0 5

Registrar Por Unpend Item 23a,27,28a-f per me G847 9-12-05 tas

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BRUCE HAMILTON SMITH August 20 2005 11:49p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 304 Mount Field Lane Apt. Anne Arudnel CO Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 212.03.7796 Usual Residence of Decedent Yrs Director NEWYORK 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director the 10f. Zip Code 10g. Citizen of What Country? JILDFORD RD 1060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married ò If Yes, Give Year or Dates: 88-42 Baltimore, Maryland 21215-0036 1 Yes 2 No HITE Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) BIOMEDICAL EN JUPMEN'T other permit. Pages 1 and 2 should be filed.
Depertment of Health and Mental Hyginimportant: If item 27 is marked other eny injury or other traumation. 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname Be ROUCE ALAN SMITH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1266 CUILDERO RO. CHENS HRISTINE DAWN SMITH ANIE, MD. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease or complications the eaused the shock, or heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Narcotics and alcohol intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initiation cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. I 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ၉ SCENE After th Pound: Day Year) 28b. Time of unk 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: unk 1 Natural 5 Pending death. 1 ☐ Yes 2 No investigation 2 Accident 8-20-05 after death Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Bural Route Number, City or Town, State) 304 Mount Field Lane Glen Burnie, MD 28e. Place of İnjury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide Home Glen Burnie, 24 hours a Medicai 29a. Certifier Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME AUGUST 21, 2005

State Registrar

Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND, 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 2 5 2005

			1 - For State Registrar	State of Maryland	d / Depa <i>Ce</i>	artment of F rtificate of	lealth and N <i>Death</i>		en 2 005	27791	
	Dhooisi		1. Decedent's Name (First, Middle, Las	t)			-	2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medio		Delphia			Soler		August	19, 2005	2:20 a M	
	Examir	ner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death		
			101 Geroed Av 5. Social Security Number 6. Se	Jenue 7. Age (In yrs. Ia	et hirthdayl	Reiste:		Baltimore Birth Baltimore			
h	Funeral Director			□M 2ÅF 85	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 14,	(Year) 9. Birthplace (State or Foreign Country) West Virginia		
	yland now		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits	
	a-fsh	ctor	MD Balt	timore		Reisters	town			1 ☐ Yes 2🛣 No	
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	10e. Street and Number			10f, Zip Code		10	g. Citizen of What Co	untry?	
	ath w		101 Geroed	Avenue			21136		U.S.A.		
	er de Items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
5	irs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White	
212-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturat", or frems 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	. 1	6b. Kind of Business/l		
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2	hould d Mer narke natic	2	Elmer 19a. Informant's Name/Relationship (7	Knotts	10h Maili	- Address /Ctract	Ma	·	Lipscomb City or Town, State, Z.	-0-11	
	d 2 sl th an t7 ls r traur		Joseph F. Soler	Husband		Geroed A			vn Marvland		
ည်	Heal Heal tem 2		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	1		Oc. Location - City or T		
<u> </u>	Pages ent of ht: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemovai from State		natory or other place.	. Ser 8/20	/05 H	ampstead,	Maryland	
Saltimor	permit. Pages 1 and 2 should be Department of Heath and Ments Important: If item 27 is marked any injury or other traumatic or once.		21. Signature of Funeral Service Licen		T .	2. Name and Addre		-	Reisterstov		
מ	Depa Impo any ir		> Slepher	m Jenkin	EL	INE FUNE	RAL HOME			cyland 21136	
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√ 'na/a	cate be executed physician and it the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequ c. Due to (or as a consequ d.							
.O. DOX	or the Hospital or Attending Physician: The law requires that the death certifulate thours after death, within 24 hours after death. Or the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic pregnancy ☐ Other (specify) _	/		23d. Date of deliv Month	rery Day Year	
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ž	en sig	ed b	CVA, Obesity, a	malphorillo	hon	pulmo.	nary	1 ☐ Yes	2XNo 3□Pro	bably 4 Unknown	
necorus,	The law re te has ber age 2 sho	ompleted by	fibrosis				<u> </u>	24a. Was an autopsy performs	prior to co	opsy findings available ompletion of cause of	
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5	hysic his ce I direc	70 6	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Residen	ce 6 Other (Speci	fy)	
	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe how	injury occurred		
NSION :	tendi leath. tor; A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
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	to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2 secondinates.	Aedical	one) 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinati and manner stated.	rledge, deatl on and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and due t	o the cause(s)	
1	viit To	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signed (Month,	, ,	
	1		KWeisham				62975	8	119/200	5	
	9		30. Name and address of person who of 295 Stoner Ave #				21157				

DHMH 17 Rev 1/2001

Registrar

AUG 2 5 2005

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State of Maryland / Department of Health and Mental Hygien 2005	2779
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2	9		1 - For State Registrar	State of Maryland		rtificate of i		Reg.		61136
10	n Physic	:	1. Decedent's Name (First, Middle, Las				2	. Date of Death Month	Day Year	3. Time of Death
10	- Physic /Med		D	orothy F. Si	llver	burg		Aug. 2	3^{Day} 200^{Par}	10:05 PM
2	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Tourson		4c. County of Death	re County
3	52 A	2	Gilchrist Home 5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	Towson	Date of Birth		
3	- Funeral Director	_	219-34-1895	-	66 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	1938 M	hplace (State or Foreign untry) laryland
12	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
26	ne Many 8a-f ah	ector	Maryland N/A		Ва	altimore	e			1X∏XYes 2 ☐ No
文	or death with the Marylar tema 23a or 28a-f ahow	Funeral Director	3939 Roland Ave	nue Apt. 6	502	10f. Zip Code	21211	10g.	Citizen of What Co	untry? USA
00 Re	72 hours after death with the Maryland 72 hours after death with the Maryland instural', or itema 23a or 28a-f ahow disal Exactions must be a collified at	Completed by Funer	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2X☐XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	ispanic Origin? (Speci an, Mexican, Puerto Ri Specity:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
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3	/ICIT	To Be	Thomas A. Davis				F1orenc	e D. B	ırke	
	Maryland nd 2 should be fil alth and Mental H alth and marked of r traumatic even		19a. Informant's Name/Relationship (7) Doris Westfall	ype, Print) Daughter		-	and Number or Rural F e Street			
NEX	Dalkimore, Maryland ZIZID-UUJO permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If tem 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Exercit any injury or other traumatic event, the Medical Exercit any injury or other traumatic event.		20a. Method of Disposition 12 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	1 00	meteni crer	sition (Name of matory or other place awn Memo	orial 8/		c. Location - City or 3 y kesvi11	
) ,' (Daliti permit. Departm Importa any inju		21. Signature of Juneral Service Licens	600	22	Name and Addres			eral Hom	e, Inc.
0			23a. Part1. Enter the disease or comp shock, or heart failure. List only of	lications that caused the death						Approximate
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	e law re has ber	Completed by	Hart Jailu	w, stro	1ce	Dias	setes	24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
-	ding Physician: The h. After this certificate he funeral director, page		mellitus, t	typentens	cai			performed		2□ No
7	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		t 30 DOA Othi	26. Place of Death (1/
7	Phys or this	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injun	/ at 28	5 Residence d. Describe how i		14) 1705p160
	ath. T: Afte	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	k? Yes 2 □No			
	or Attendiate death Director: A	ertific	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho- building, etc. (Specify	me, farm, str	eet, factory, office	28	f. Location (Stree City or Town, S.	t and Number or Rui tate)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my know iner: On the basis of examinate and manner stated.	vledge, death ion and/or inv	occurred at the time vestigation, in my of	ne, date and place, and pinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	ny Melen	(hrs	29c. License	2902	29d.	Date signed (Month	Day, Year) 2 4 2005
	H		30. Name of address of person who c	1 from (-701	23a) (Type	Print) les S	+ Balto.			t
		ate	31. Date filed (Month, Day, Year)	32. Redistrar's Signat	ure	1 - 4				
	Regist	rar	AUG 2 5 2	UUS Alekers	15. B	0000				

05-05658 Alan C. Smith RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

27793

Physic	ian	Decedent's Name (First, Middle, Last	")	per me 6849 Certificate of			212005ar	3. Time of Death
/Medi Examii	cat	4a. Facility Name (If not institution, give Rear of 3542 Ash	Alan Charles S street and number) Street		or Location of Death		4c. County of Death	
Funeral Director		217 74 3910	x 7. Age (In yrs. last XMM 2□F 46	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea ec. 15,	9. Birthp 1958 Mar	place (State or Foreign htry) yland
e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		own or Location 1timore			1	1 Od. Inside City Limits
ith with th	ai Director	10e. Street and Number 6 - Third Aven	ue	10f. Zip Code	225	10g. (Citizen of What Cour	ntry?
72 hours after death with the Maryland natural; or items 23a or 28a-f show Jical Exacting frout be profiled at	by Funeral I	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubi	dispanic Origin? (Specif an, Mexican, Puerto Ric Specity:	y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depentiment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itama 23a or 28a-f show ery injury or other traumatic event, the Medical Experiment interior or extilled at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	cation 16 (e completed) College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Disabled	oation during most of working d)	16b.	Kind of Business/In	dustry
should be file and Mental Hy marked other	To Be C	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Char1	es Smith		18. Mother's Name (F Margue	irst, Middle, Maid erite Gro		
and 2 sho ealth and I m 27 is ma		19a. Informant's Name/Relationship (T) Charles Smith /	Father	9b. Mailing Address (Street 6 - Third Ave	enue Bal	timore,	Maryland	21225
Depermit. Peges 1 au Depertment of Hea Important: if item eny injury or othe		20a. Method of Disposition 1 \(\mathbb{X}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{F}\) 4 \(\mathbb{D}\) Donation 5 \(\mathbb{O}\) Other (Specify) 21. Sign the pt Fulleral Service Loans	Removal from State Cedar	of Disposition (Name of stery, crematory or other place Hill Cemete 22. Name and Addre		005 Ba	Location - City or To 1timore, N	Maryland
permi Depe Impo eny is		23a. Part1. Enter the disease, or comp	landge	4001 Ritch	nie Highway	Baltim		
certificate be executed defined by Science and ding physicien and see as the burial-transit	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sous Italy liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Coronary artery cardinovas curtain of the coronary artery cardinovas curtain of the coronary artery cardinovas a consequence coronary artery artery coronary artery cardinovas a consequence coronary artery cardinovas a consequence coronary artery cardinovas artery	pe of):	licating at	heroscle	erotic	Onset and Death
death ce a attendi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		/		23d. Date of delive Month	ery Day Year
iaw requires that the es been signed by the 2 should be detache	۵	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to the	L
Physician: The law requires t r this certificete hes been signe rral director, page 2 should be o	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of 2 No
ysicia nis cert directe	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA Oth	26. Place of Death Coner. 4 Nursing Home		6 StOther (Specific	(scene)
To the Hospitel or Attending Physician: The i within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Alatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	D. Time of 28c. Injury Wor 1	yat k? Yes 2 □ No	. Describe how in		· (Secric)
itef or At rs after d ref Direct led in by		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f.	Location (Street City or Town, Sta	and Number or Rura ate)	il Route Number,
he Hosp in 24 hou he Funei pletely fill	edicai	29a. Certifier 1 Certifying Phy (Check only one) 4 Decirios Certifying Physics Certifying	sician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death occurred at the tir and/or investigation, in my o	me, date and place, and pinion, death occurred	due to the cause at the time, date a	(s) and manner as si and place, and due to	ated. the cause(s)
To the within To the comp	Ž	29b. Signature and title of certifier	/ \/: •	29c. Licens O.C.I		Aug	Date signed (Month UST 22, 20	Day Year)
		30. Name and address of person who co	MIX news					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005

			1 - For State Registrar 1. Decedent's Name (First, Middle		iai yiai iC		tificate					Reg. No.		27794
*	Physici		William H. Swinton								Month	22,		6:12 PM
	/Medio		4a. Facility Name (If not institution,		7)		4b. City. T	own, or					County of Deat	h
		4 4		40 15AL 0	F BAI	TUMOR	If Under 1	×4.	If Under	10 P		4h	O Bird	halan (State of Free lead
	Funeral Director		5. Social Security Number 250–50–0274	6. Sex 7. A	ige (In yrs. la 73	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 08-30-19	y, Year)	Sout	hplace (State or Foreign untry) h Carolina
	p .		Usual Residence of Decedent		1.0 0									
	the Maryland 28a-f show notified at	ž	10a. State 10b. County		10c. City,	Town or Lo								10d. Inside City Limits 1 XYes 2 ☐ No
_	the M	Director	MD N	IA		Ba	ltimore 10f. Zip (10g. Citi	izen of What Co	untry?
3	death with the ims 23a or 28a r must be not		3403 Alto Road				2	1216					USA	
3	atter deat or Items 2	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	6. 13.	Was Decede	ent of His fy Cubar	spanic Orig	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit	
36	is atter death with the Maryla ', or items 23a or 28a 4 sho caning must be notified at	by F.	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 X If Yes, Give Year or Dates			1 ☐ Yes 2						Specify: D1	ack
Z	within 72 hours atter ene. than "natural", or ite	ted t	15. Decedent	's Education		16a. Dece	dent's Usual	Occupa	ition	t and commentation	-	16b. K	ind of Business/	
215	thin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4o	r 5+)	lite.	kind of work DO NOT use	e retired)	u <i>ri</i> ng mosi	OF WORK!	ıg			
9 2	iled wi tygien her th		5 17. Father's Name (First, Middle, I	251			We1		18 Mothe	r's Name	(First, Middle		Construct	ion
WINTOW aryland 212	d be ti ental h	o Be	17. Father S Name (First, Middle, 1	unknown							Flowers		Garrianio	
WINTON 1	shoul and Ma mark umati	L L	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a					or Town, State, 2	Zip Code)
V≥	and 2 salth s n 27 ls	١,	Iris Burrell/	Daughter	1				Carlo Carlo		21216			
Baltimore	permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Important: If item 271s marked other than any injury or other traumatic svant. Ite Magnee.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation		9	ace of Dispo metery, crer					ate		ocation - City or	
II.	srtmen srtmen ortant: njury	ļ,	4 ☐ Donation 5 ☐ Other (S)		Ceda	ar Hill	Cemete Name and			8-2 7- 0 v)5	Glen	Burnie, 1	MD
Ba	Depa Impo any is									•	88 N. Gi	lmor s	St. Balto	, MD 21217
			23a. Part1. Enter the disease, or shock, or head failure. List	complications that caus only one cause on each	ed the death. line.	. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. VEN	TRILL	MAR	TA	Ltun	CAR	-0V	+			Onset and Death 20 MINUTES
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):			'					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	- N	is a consequ									
V	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	ite be execu iysician and ie burial-tra	ical Ex	1050king in dodany Eust	Due to (or a	as a consequ	ence or):								
				d								1		
X	eath certifica attending ph for use as th	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	anancv					23d. Date of del	
P.O. Box 68	ne deal the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of de		Other (spe						Month	Day Year
		P.	Part II. Other significant condition	ns contributing to death	but not resu	Iting in the u	nderlying ca	iuse give	n in Part I.		23e. Did 1	tobacco (use contribute to	the cause of death?
Division of Vital Records.	w requires been sign should be	d by									1 🗆	Yes 2	© No 3□Pi	obably 4 Unknown
Ö	aw requisibeen	Completed									24a. Was		24b. Were au	utopsy findings available completion of cause of
Ä	Physician: The lav this certiticete has al director, page 2	HOC									perfo	ormed?	death?	
Vita	ician: certitic ector,	Be	25. Was case referred to medical examiner?	Hospital:		,		Othe			(Check only			
of	Phys r this ral dir	. To	1 Yes 2 No 27. Manper of Death	1 ☐ Inpa 28a. Date of In (Month, L		ER/Outpatier 28b. Time o		A Bc. Injury Work	4 🗀 190		ne 5 🗌 Resi 28d. Describe		6 □Other (Spe ry occurred	cify)
jon	uttending Ph death. ctor: After th y the funeral	atior	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	9	Day Year)	Injury	м		d? Yes 2□	No				
× ×	al or Attend efter death Director: d in by the t	Certification:	3 Suicide 6 Could i	inned 289, Place of t	Injury - At ho	me, farm, sti	reet, factory,	office		2	28f. Location (City or To	Street ar	nd Number or Re	ural Route Number,
٥	To the Hospital or Attenwithin 24 hours effer deal To the Funeral Director: completely tilled in by the		29a Certifier 1 Certifyin	g Physician: To the be	et of mu lene:	woden deet	h oos	at the a torre	na data ==	nd place	and due to the	09/19=/-) and manages	ctated
	E Hos 24 ho E Fune etely t	Medical		Examiner: On the basis and manner	of examinat									
	To the Hospital of within 24 hours of To the Funeral D completely tilled in	Me	29b. Signature and title of certifie		/		29c.	License	number			29d. Da	te signed (Mont	h, Day, Year)
			9		Mi	9.	B	680	1130	53	,	ALL	ust 22	,2005
	1	į į	30. Name and address of person	1	f death (Item M.D.	23а) (Туре,	Print)	10	lan l	V		۸Ŧ	BALTU	4 4 2 5
	· St	ate	31. Date filed (Month, Day, Year)	32 Regi	strar's Signat	ure)1/9	711	109	11/4	<i>v</i> ·	07011	-0-6
	Regist		AUG 2 5	2005	A	& An	actis							

			1 - For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	lental Hygien		27795
s2	Physici		1. Decedent's Name (First, Middle, Last,	4 TRE	NT	2. Date of Death Month Date of Death Month AVGUIT 2	ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		c. County of Death	MORE
	Funeral Director		Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Second Security Number 6. Second Second Second Security Number 6. Second		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year	9. Birthpla	ce (State or Foreign
	ס		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	Гергази		d. Inside City Limits
	the Man 28a-f sh notified	Director	Mary and NA	Balt	100 CODE	10g. C	itizen of What Countr	1 Yes 2 □ No
	a 23a or	erai Di	2134 Mt. He	12. Was Decedent Ever in U.S. 13. V	21216		USA 14. Race - America	
36	within 72 hours efter death with the Maryland ene. than "natural", or itema 23s or 28s-f show he Mydical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, et	
21215-0036	n 72 hour natural	leted t	15. Decedent's Edu (Specify only highest grad	cation 16a. Deced	dent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing 16b. I	Kind of Business/Indu	estry
	filed withii Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	omestic Ser	Vant P	rivate	Home
Maryland	should be f nd Mental h marked of umatic ever	To Be	Henry Hen	ley	Ida	Seay		
	01 00 00 00		19a. Informant's N me/Relationship (Ty	iders 680	ng Address (Street and Number or Rura O Liberty Rd	1002 Ba	Uto. Nd	.21244
Baltimore,	Ly and Pa		20a. Method of Disposition 1 Maurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	temoval from State	isition (Name of matory or other place)	Date 20c. 1 1/2005 7	Location - City or Tow	n, State
Balt	permit. Pa Depertmen Important: any Injury once.		21. Signature of Funeral Service Licens	ep / , /) 22	Name and Address of Facility	neral Home	P.A.	16
	Dhi.i.		23a. Part. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ications that caused the death. Do not ent ne cause on each line.	er the mode of dying, such as cardiac of		1	Approximate nterval Between Onset and Death
1	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	1/01/11			
	ed	niner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
8760,	cate be executed physicien and the burial-transit	i Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
9	artificate ing physi e as the b	Medicai	IF FEMALE:	1.				
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	/ Pay Year
	uires that signed b Id be deta		Part II. Dther significant conditions co.	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Vital Records,	e law require has been sig ge 2 should b	Completed by				24a. Was an autopsy performed?	24b. Were autops prior to com- death?	sy findings available pletion of cause of
ital F	ysician: The is certificate hadirector, page	Be Col	25. Was case referred to medical examiner?			1 Yes 2 XX		Caro
of	ding Physician: After this certification of the director.	은	1 Yes 2 No	lospital: 1	The state of the s	me 5 Residence 28d. Describe how inju	- ''	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 □ Yes 2 □ No	28f. Location (Street a City or Town, Sta		Route Number,
۵	ospitai o hours afi unerai Di	ledicai Cer	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death	h occurred at the time, date and place,	and due to the cause(s) and manner as star	ted.
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	ate signed (Month, D	ay, Year)
)			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	D'37'3.		445T 23	,2005
	<u></u>		31. Date filed (Month, Day, Year)	MO, NHL,	BALTO MI	2113	5	
	Sta Registr		AUG 2 5 2005	Block of April	2			

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			1 - Stata Registrar		Ce	rtificate of D	eath	R	eg. No.	
	Dhi.i		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	th Day Yea	3. Time of Death
	Physici /Medio		Joseph	Bernard	I To	pper, Jr.		Aug 22,	2005	1:05 p M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or L	ocation of Death		4c. County of De	eath
			Good Samaritan			Baltin				
	Funeral Director		5. Social Security Number 213–66–5457	3. Sex 7. Age (In 1 1	n yrs. last birthday 51 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Nov. 19	, Year)	Birthplace (State or Foreign Country) MD
	σ		Usual Residence of Decedent					11001. 12	,1,55	110
	nylan how		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	e Ma	cto	MD Balti	more	Rei	sterstown				1 ☐ Yes 2 No
	를 다 or 22	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	ath w	ral	37 Brookshire D	rive		21	136		USA	
	ar de tams	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	nerican Indian, hite, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	IT- 4 -
8	tura	edt	15. Decedent's		16a Dece	dent's Usual Occupati	on.		16b. Kind of Busine	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23s or 28s-f show than "natural Examinar in the be invitted at	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done du DO NOT use retired)	ring most of work	ing	Tob. Italia of Dasille	samuusii y
212	d with giene ir tha	EO	12	College (1-4or 5+)	Ex	terminator	:		Pest C	ontrol
	a file of ha	BeC	17. Father's Name (First, Middle, La	ist)				e (First, Middle, I	Maiden Sumame)	
<u>la</u>	uld b Mente rrked	ToE	Joseph B. Toppe	r, Sr.			Miriam	Gormley		
Maryland	2 sho and ? Is ms		19a. Informant's Name/Relationshi	o (Type, Print)	19b. Mail	ing Address (Street an	d Number or Run	al Route Number	, City or Town, State	, Zip Code)
	and and not not not not not not not not not not		Susan M. Topper	Wife		Brookshire	Drive,	Reisters	town, MD	21136
ore	jes 1 and of Health If itam 27 or othar tu		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3		20b. Place of Disponentery, cre	osition (Name of matory or other place)		Date	20c. Location - City	or Town, State
Ē	Pag ment ant:		'4 □Donation 5 □Other (Spe		Carrol1	Cremation	Aug 2	24, 2005	Hamps	tead, MD
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked othar than "natural", or itams 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinar must be notified at once.		21. Signature of Euneral Service Li	censee	, 2	2. Name and Address	of Facility	11824	Reisters	town Road
_	₹ 0 € 6 0		regue.	manpor		Eline Funer			erstown,	MD 21136
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	nly one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Atherosc	levatic	Canliove	scul	DIJEA	2	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co						
		-	Sequentially list conditions,	b Due to (or as a co	negatione of:					
Γ	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (0) as a co	risequence or,					
	certificate be executed ding physician and se as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):					
68760,	siciar siciar s buri		(d						
687	ificate g phy as the	edicai		d						
ŏ	0 6 3	Σ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		7 -			23d. Date of c	lelivery
m	The law requires that the death or all the atten atten been signed by the atten page 2 should be detached for u.	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 □ 4□Pregnant at time		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P. O.	t the by the tache	hys	9 🗆 Unknown	9□ Unknown						
	stha gned	by P	Part II. Dther significant condition		ot resulting in the u	inderlying cause given	in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
rd	w require been sig should b		DIAF	eles				1 □ Ye	s 2 1 No 3 □	Probably 4 Unknown
Records,	e law re has beo	Completed						24a. Was a	n 24b. Were	autopsy findings available o completion of cause of
	The ate has page	E O						autops perform	ned? death	es 2 No
ita	ysician: The is certificate hadirector, page	Bec	25. Was case referred to medical			2	26. Place of Death			
<u>></u>	hysic nis ce	70	examiner2 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ENOutpatie	nt 3 DOA Other:	4 Nursing Ho	me 5 Reside	nce 6 □Other (S _i	pecify)
Division of Vital	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injury a Work?	t	28d. Describe ho	w injury occurred	
sio	tandi eath. tor: A the fu	cati	2 Accident investiga 3 Suicide 6 Could no	t be			s 2 No			
\leq	or At fler d Diract in by	Certification:	4 Homicide determin		At home, farm, st Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or . n, State)	Rural Route Number,
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	24 hos Fun stely	Medicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my caminer: On the basis of exa and manner stated.	y knowledge, deat imination and/or in	n occurred at the time, vestigation, in my opin	date and place, ion, death occurr	and due to the ca ed at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Me	29b. Signature and title of certifier	and manifel stated.		29c. License n	number	25	9d. Date signed (Mo.	nth, Day, Year)
ì	->-0		· h. 00	X De a		0271	2.7		8/23/05	
	/		30. Name and address of person wi	no completed cause of death	(Item 23a) (Type.				ر در ارجار	
	6		V	مادمید عد	7. MA	12 01	Reister	town.	my 7	_(()(
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	. 90 8				
	Registr	ar	AUG 2 5 21	105 8000	CF CAGE	A Comment of the Comm				

State of Maryland / Department of Health and Mental Hygien [6] [7] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 11:10 AM 05 Ma /Medical 4a. Facility Name (If not institution, dive street and number, Examiner 4c. County of Death remoria Baltimoder 1 Year | If Under 2 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 215-12-4678 Usual Residence of Decedent 1□ M 2 🔽 F Director the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? filed within 72 hours after death with or items 23s 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 I If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 2 No 3 Widowed 4 □ Divorced Black "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ake 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be fi permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any failury or other traumatic averaging. 19a. Informant's Name/Relationship (Type, Print) Great 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nephew 20b. Place of Disposition (Name of cometer, crematory of other place) 20c. Location - City Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 1 DBurial 2 □ Cremation ure | Fune a Service Lic. 22. Name and Address of Fad Cremation Center Alternatives Funcial and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner orwary Anten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a equence of): use as the burial-transit The law requires that the death certificate be executed ocked in SUN signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 ☐ 10 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. MARITA MIKE 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Marita East MD BAT. MD 2/2/8-289 MIK

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

		For	1 10000	State of Ma	aryland / D	epartment of	Health and M		gien 2005	27798
		1 - State Registrar 1. Decedent's Name	(First Middle Las			Certificate of	Death		leg. No.	2 Time of Death
	sician edical	/ intra	ANN L	JALTER	2			Month	Day Year	3. Time of Death
	miner		not institution, give	street and number)	1	4b. City, Town,	or Location of Death	1.030	4c. County of Deat	h
Funer	ral	5. Social Security No.			edical Ce e (In yrs. last birt	hter olen hday) If Under 1 Year		8. Date of Birth	Hnne Hru	hplace (State or Foreign
Direct		179-46-8 Usual Residence of	7 (7	□ M 2 🖫 F	50	rs. Months Days	Hours Min.	Month Day		NSYLVANIA
ryland rhow		10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
the Ma	ecto	10e. Street and Num	ANNEAR	UNDEL	HASAR	10f. Zip Code			On Citizen of Miles O	1 ☐ Yes 2 No
-0036 hours after death with the Maryland turel; or Itams 23a or 28a-f show at Examinan must be notified at	Funeral Director	4368 MO	WTAIN R	D.		211	22		Og. Citizen of What Co	ountry :
ter dea	uner	11. Marital Status 1 □ Never Marrie		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑	_	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
0036 ours aff	J A	3 ☐ Widowed		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: W	ITE
0 2 E	Completed	(Ѕрвсі	15. Decedent's Ed fy only highest gra	de completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Business/	Industry
d 21215- filed within 72 Hygiene. ither then "nei	Com	Elementary/Secor	ndary (0-12)	College (1-4or 5	5+) 5	LDER AS	*	ź	ELECTRO	vies_
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re, Maryla s 1 and 2 should Health and Men Item 27 is marke other treumatic	P		me/Relationship (7	Гурв, Print)	19b.	Mailing Address (Stree			KENBUK City or Town, State, Z	
C = W F		KIM WALT 20a. Method of Disp	ER, HUS	BAND	43 20h Place of	SHOUNTAL Disposition (Name of	The state of the s	-	121122	
daltimore, mit. Pages 1 ar spartment of Hea portant: If Item y injury or othe		1 🗆 Burial 2	_	Removal from State	Cometen	crematory or other pla		-05 F	20c. Location - City or	Town, State
Baltimos permit. Pages Department of Important: If it		1	ne al ervio Licen		- Injuice	22. Name and Addr	ess of Facility		JUNIONE	, roly
o 8855	a	23a, Part1, Enter th	e disease comp	plication that cause	the death Do n	260 ot enter the mode of dy	Family Funeral Ho 1 Mountain Road	me And Crema Pasadena, M	ation Center, P.A.	Approximate
Frysicia	ur 200	shock, or hear Immediate Cause (I disease or condition	rinai	one cause on each li	ne.	Λ -	mig, suori as cardiac c	Toophatory unit	001,	Interval Between Onset and Death
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r 68 ortificate ing phy e as the	Medic			o		-				
BOX 6: leath certific attending p	Physician/Med	23b. Was decedent in the past 12 r	nonths?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of deli Month	very Day Year
at the de	hvsi	1 ☐ Yes 2 € 9 ☐ Unknown	No	9□ Unknown		o El otrior (appearly)				
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VISION OT VITA Attending Physicien: r death. ector: After this certifica by the funeral director.	I			1 Ampatie 28a. Date of Inju (Month, Da		patient 31 DOA	4 Inursing Ho		ence 6 Other (Spec ow injury occurred	eiry)
DIVISION I or Attending after death. Director: After in by the fune	licati	2 Accident 3 Suicide	investigation 6 Could not be				Yes 2□No	28f Location (St	reet and Number or Ru	ral Pouto Number
		4 Homicide	determined	building, etc	c. (Specify)	m, street, ractory, office		City or Town	, State)	iai noute ivuilizer,
Hospital 24 hours 6 Funerel I	edical		1 Certifying Phy 2 Medical Exam	ysician: To the best of tiner: On the basis of and manner sta	examination and	death occurred at the ti	ime, date and place, a opinion, death occurr	and due to the ca	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the Hospital or within 24 hours at To the Funerel D	Me	29b. Signature and t	itle of certifier	and manner sta		29c. Licen	se number	25	9d. Date signed (Month	I, Day, Year)
01		1	has?	Lule	to m	0 0	CO748	187	August 1	7 2005
21		20. Name and addre	ss of person who o	completed cause of d	eath (Item 23a) (1	Type, Print) Luc	Dical C	e dev	Glan 1	Burnia UM
	Statě	31. Date filed (Month	-	27.	ar's Signature	Agreed .	711		1	
Regi	istrar	A	UG 2 5 20	UU JURAN	and while of	KI STONE STO				

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State of Maryland / Department of Health and Mental Hygien 2005

			1 - State Registrar	Cer	tificate of D	eaith and iv		leg. No.	000	21199
	Physici	an	1. Decedent's Name (First, Middle, Last) Raymond H. Worley	, Jr			2. Date of Dea Month	Day	Year	3. Time of Death 8:30 Am
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	OI	4b. City, Town, or L	ocation of Death	August	23, 4c. Co	2005 unty of Death	0.30 //
			7400 01d Harford Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birt		Baltimore	If Under 24 Hrs.	1 a B (B)		Baltimore	
	Funeral Director		218-78-0925 1'X™ 2□ F 71	Yrs.	Months Days	Hours Min.	8. Date of Birth Month Day Mar Ch 25,	1 9 34	Mary	lace (State or Foreign (nv) and
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	vn or Lo	cation				1	0d. Inside City Limits
	e Man Ba-f sh	ctor		timor	e					1 ☐ Yes 2 X No
	and the second	I Dire	7400 01d Harford Road		10f. Zip Code 21234				of What Coun SA	try?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or items 23a or 28a-f show to marked other than "neturel", or items 20a or 28a-f show termitic event, the Madical Examination.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spo , Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
036	urs afte el', or i	by	1 M Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates:		_	Specify:			ecity: White	
Maryland 21215-0036	"netur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a.	(Give I	lent's Usual Occupati	ion ring most of work	ing	16b. Kind	of Business/Inc	lustry
212	d withingiene.	omo	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired)			Disab	led	
and	l be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) Raymond H. Worley Sr.			8. Mother's Name		Maiden Sui	mame)	
200	should nd Me mark metic	To		o. Mailin	g Address (Street an	Lillian W. Id Number or Rura		r. City or To	wn. State. Zip	Code)
	d 2 th a		Wendell Powell/Cousin 415	55 Ho	olbrook Lane					,
Baltimore,	Page ent o nt: If ry or		1 Burial 2 VCremation 3 DRemoval from State Cemeter	ary, crem	sition (Name of natory or other place) Vice Corp.	8/25/	Oate		on-City or To On Maryla	
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Licensee Chrisina L. Hi Christina L. Hi							
			23a. Part1. Enter the disease, or complications that caused the death. Do n						ore Mu	Approximate
	Physician		shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition	Ke	you	and!	m	er	l.	Interval Between Onset and Death
þ	/Medical Examiner		resulting in death) Due to (or as a consequence of	of):	8		0		i i	
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	of):						
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68760,	death certificate be executed e attending physician and id for use as the burial-transit	Medical	d							
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\mathbf{r}	Physician: The lav this certificate has al director, page 2	Completed	Jana a	07			autops perform	ned?	prior to con death?	sy findings available inpletion of cause of
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	To the Hospitel or Attending Physician: whin 24 hours after death after this certification to the Funerel Director: After this certification in the funeral director; to mplately filled in by the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director	edical C	29a. Certifier (Check only one) 29a. Medical Exeminer: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner of examination and control of the cont	e, death	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	and due to the ca	ause(s) and ate and pla	I manner as sta	ited. the cause(s)
	To the within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License n				gned (Month, E	
			MMM cs.		200	0358	- 1	Alej	24	Swe
	3		30. Name and address of person who completed cause of death (Item 23a) ((Туре, Р	Print) 840	3 H	ARTO	Reis	1010	21/23
	Sta Registra	_	31. Date filed (Month, Day, Year) AUG 2 5 2005	So	arles			1 600	The Contract of the Contract o	- · - 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 1 15 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** WILLIAMS ICE. AUGUST 12:30 AM MAUR /Medical 2005 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 111M 2∏F Hours Yrs. Director 148-62-1599 43 06-05-1962 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits s 23e or 28e-f show ust be notified at 1 ☐ Yes 2 No Director Md **Baltimore** Windsor Mill 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to the Health and Mental Hygiene. Int: If item 27 ie marked other then "neturel", or Items 23e or? 8312 Tinsley Road 21244 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Affiled Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1☐Yes 2₽√No Specify: þ ar then "neturel", 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 ie marked other then 'r treumetic event, Il e Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Disable Disable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Lawrence Williams Christine Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 ie r or other tree Lawrence Williams (Father) 8312 Tinsley Road Windsor Mill, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State Department or Importent: If eny injury or Comfort Crematory 08-29-2005 Alexandria, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funer | Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prrysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 s autopsy performed 2□ No 2 **2** R 1 Yes Yes 25. Was case referred to med 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 Certification: To 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D

completely

31. Date filed (Month, Day, State AUG 2 5 2005 Registrar

29b. Signature and title of certifier

29a. Certifier

Medical

WORRETT 32. Registras's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

65

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygie [] 5

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WATERS AGNES AUGUST 15 2005 4:06 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 10 F Director 217-14-7215 84 Yrs DECEMBÉR MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location irel', or items 23e or 28a-f show Examiner must be notified at 10d. Inside City Limits Director MD 1X Yes 2 □ No PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9513 BADGET AVENUE Funeral 20735 S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 by 1 ☐ Yes 2 X No 3 Widowed 4 Divorced BLACK neturel Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other then " Elementary/Secondary (0-12) College (1-4or 5+) 7TH PRESSER PRIVATE other treumetic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill traint of Health and Mental H tent: If item 27 is marked out 18. Mother's Name (First, Middle, Maiden Sumame, Be WILLIAM D. WATERS ELLA NEWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a MARY GREENFIELD/DAUGHTER 15115 MARLBORO PIKE UPPER MARLBORO, MARYLAND 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 8/25/05 CLINTON, MARYLAND 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician CARDIOPULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** GI BLEED (upper) Sequentially list conditions, if my cause. Enter Underlying Cause (Disease or injury Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĺ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) PO the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No autopsy performed? 1 🔲 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 □XYes 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 MNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifie (Check only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 100343 of deal (Item 23a) (Type Print) 30. Name and address of person who completed SOUTHERN MARYLAND 1405 CARTER M.D 7503 SURRATIS ROAD CLINTON, mA. 20735 gistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiere 0 0 5 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** AUGUST Pay. 5492 Annabelle 3:30P C. Zero /Medical 4a. Facility Name (If pot institution, give street and number)
Saint Joseph Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore lowson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 ☑ F Director Yrs. 214-20-9477 79 May 5, 1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hyglene.
snt: If Item 27 is marked other than "naturel", or items 23s or 28e-1 ehow ary or other treumatic event, I'm Medical Examiner is ust be retiffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Marvland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8000 Kimberly Road 21222 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 2 1 Yes 2010 Specify: 3X Widowed 4 □ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lyman Colditz 2 Irene Johnson 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon A. Hornberger 563 West Drive Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. injury or * 4 □ Donation 5 □ Other (Specify) Oak Ławn Cemetery 8/25/2005 Baltimore, Maryland 21. Signature of Fundal Service Lipenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ligite. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIC **Physician** ENCEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of):
CARDIOGENIC SHOCK **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): certificate be executed use as the burial-transit MITRAL REGURGITATION resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 Pregnant al time of death 5 ☐ Other (specify) Day Year P.0. 9☐ Unknown 9 Unknown ۾ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 99 ACUTE RENAL FAILURE Completed 2 X No 1 Yes 3 Probably 4 Unknown peen ATRIAL FIBRILLATION 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No 1 Yes 1 🗌 Yes Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death Medical Certification; 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. investigation within 24 hours after death To the Funerel Director:, completely filled in by the f 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 🗌 Homicide 1)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30263

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

32. Registrar's Signature

7601 OSLER DRIVE TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO M.D.

AUG 2 5 2005

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 005 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Peter Zozulak 2005 August 4:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 200 W. 11th Avenue Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Mar. | 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**∑** M 2□ F 212 32 3653 85 Director Yrs **1**920 Ukraine Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, it is Mudical Examiner must be notified at 10d. Inside City Limits Maryland Director Anne Arundel Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 W. 11th Avenue 21225 Ukraine 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 à 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Ø Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Body & Fender U.S. Postal Service permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 Is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mukola Zozulak Teodora (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Zozulak / Daughter 200 W. 11th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō * 4 ☐ Donation 5 ☐ Other (Specify) Michaels Ukranian 8/20/2005 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. any. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, of comshock, or heart failure. List only of complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Frysician disease or condition resulting in death) Ches /Medical Due toffor as a cons **Examiner** Secrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9□ Unknown Other significant conditions contributing to death both not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records. by 2 No Be Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No Division of Vital 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 28a Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide pellij 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) within 2 29b. Signature and title of certifier ATTENDING 29c. License number PHYSICIAN

State Registrar

Hoice 31. Date filed (Month, Day, Year) 32. Resistrar's Signature AUG 2 5 2005

016200 completed cause of death (Item 23a) (Type, Print) NORBERTO M. MACHIRAD, M.D.

CATONSVILLE, Md

State of Maryland / Department of Health and Mental Hygigns 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUĞÜST 2005 ZARRELLI 11:22 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL COLUMBIA **HOWARD** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year 12/29/1924 Birthplace (State or Foreign Country) 1 M 2 N F 147-14-2713 Director 80 Yrs N.J. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. somet of Heatth and Mental Hygiene sint: If item 27 is marked other then "natural, or items 23e or 28e-f show 10a State 10h County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits Examiner must be notified at Director MD 1 ☐ Yes 2 No HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 DORSEY HALL 21042 Items 23e DRIVE U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify 3 Widowed 4 Divorced treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) nd Mental Hygiene. marked other then College (1-4or 5+) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MONROE **JEFFERSON** LEVINE 2 VIOLA ROSENSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2917 WOODWICK COURT-ELLICOTT CITY, MD 21042 JEFF APPLEBAUM / SON item 27 other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MOSES MONTTETORE 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 8 permit. Page Department of Importent: If any injury or once. ¹ 4 □ Donation 5 □ Other (Specify) 08/24/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Priysician Myscansal INIAncho hours /Medical Due to (or as a consequence of): Examiner Anter Discome if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Abel= Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diterry 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 R/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year) 29c. License number student PK Edubra Mis son who completed cause of death (Item 23a) (Type, Print) 1105 Little 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 2 5 2005

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State of Maryland / Department of Health and Mental Hygie 05	278	305
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3	Division	E.	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month		3. Time of Dea	ith
	Physici /Medi		Harry Atanossia	n				August	4, 2005		Мф
	Examir	ier	4a. Facility Name (If not institution, giv			_	r Location of Death		4c. County of D	eath	
	*	٠ ٠	Holy Cross Hospi		la a de fada da a d	Silver	Spring If Under 24 Hrs.	1 (Montgor		
P.	Funeral Director		5. Social Security Number 6. S 036-16-5175 Usual Residence of Decedent	7. Age (In yrs. 82	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 17	Year)	Birthplace (State or Fo Country) hode Islan	. 3
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Li	mits
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21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if tem 27 is marked other then "natural", or items 23a or 28a-f show any orlant: if tem 27 is marked other then "hadical Exemples must be notified at once."	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1X∑Yes 2 □ No If Yes, Give Year or Dates: WWII		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 201 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		merican Indian, /hite, etc. Vhite	
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37	should Man	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			, City or Town, Stat	e, Zip Code)	
	end 2 eelth a n 27 le		Anne Atanossian/	Wife	10810	Drumm A	venue, Ke	nsington	, MD 2089	95	
Baltimore,	Department of Heelth Important: If Item 27		20a. Method of Disposition 1 3 3 4 □ Donation 5 □ Other (Special Control of the Control of	Removal from State	emetery, crer	natory or other planted the aven C	ce) A	ugust 8	20c. Location - City	or Town, State	land
Balti	permit. Departm Importe eny Inju		21. Signature of Funeral Service Lice	LCole	1 7	rancis O Unive	collins rsity Blv			ing, MD 209	
68760,	The law requires that the death certificate be executed as the standing physicien and unique bage 2 should be detached for use as the burial-transit	Medical Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List enty Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACUTE	uence of)	OCARI	DIAL HEA TERY	or respiratory arriv	RCTION FAILU GEASE	Approximate Interval Betweet Onset and Deat	h
P.O. Box 6	that the death certified by the attending detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year	
	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tot		e to the cause of death	
I Records,	sician: The law re certificete has be- lirector, page 2 sho	Completed						24a. Was a autops perform	y prior nede death	autopsy findings avai to completion of cause 1? res 2 No	lable of
of Vital	Physician: this certifical ral director, i	Be	25. Was case referred to medical examiner?					th (Check only on	7		
to	Physi this al dire	٦.	1 ☐ Yes 2 No 27. Manner of Death		ER/Outpatier	IL 3 DOV			ence 6 Other (S	Specify)	
u o	ding I	lon	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk? Yes 2 □ No	28d. Describe ho	ow injury occurred		
Division	Hospitel or Attending 4 hours after death. Funeral Director: After tely filled in by the funer	Certification:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	OC Discontinuo	ome, farm, str		7103 2 110	28f. Location (St City or Town		Rural Route Number,	
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical Co	29a. Certifier 1 Cartifying Pt (Check only one) 2 Medical Example	nysician: To the best of my kno minar: On the basis of examina	wledge, death	h occurred at the till vestigation, in my o	me, date and place, opinion, death occur	and due to the ca	ause(s) and manner ate and place, and o	r as stated. due to the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and tytle of centriar	and manner stated.		29c. Licens	se number	2	9d. Date signed (M	onth, Day, Year)	
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6°	Sta Regist		31. Date filed (Mohth, Day, Year) AUG 11 2	32 legistrar's Signa	ture A	arli	1		,	80110	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2005 27806 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Genevieve Clagget Allman August 6, 2005 5:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5813 Easthaven Ct. Bowie Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days 578-54-3094 Yrs. Director 92 4-16-1913 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits is marked other than "natural", or Itams 23a or 28a-f show traumatic avent, the Medical Examinar must be notified at 1XXYes 2 □ No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15813 Easthaven Ct. 20716 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Menial Hygiene. Important: If Itam 27 is marked other than "ns any injury or other traumatic event, Ita Madis. Once. (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Adam Clagget Ella Nora Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel J. Allman/Son 3012 Tarragon Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery | 8-10-05 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 29/3 Solomons Island Rd. Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death

S Lan Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due,to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit signed by the attending physician and resulting in death) Last Due or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 X No 3 Probably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2.5 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home SAResidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury al Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

completely filled in by the funeral after death Director: within 24 hours a To the Funeral I

Medical

State

Registrar

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2005

and manner stated

bakheelm. D. 4000 Mitchellville Rd. Suite 216, Bowle, 20716 32. Rastrar's Signature

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation in my relation death occurred at the time, date and place.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0026492

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydie 6e 0 0 5 27907

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			Sex 7. Ac	ie (In vrs. last b	irthday)		St St Sale of Death Month Day August 5 b. City, Town, or Location of Death Annapolis b. City, Town, or Location of Death Annapolis b. City, Town, or Location of Death Annapolis b. City, Town, or Location of Death Annapolis control Days Hours Min. Nov. 5,1924 Identify Death Hours Min. Nov.	0.00	rthplace (State	or Fore			
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th an				nd) 5	Ty	Ler Plac	ce,	Annapo	lis, MD	214	03		
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		30. Name and address of person w	o completed cause of	death (Item 23	а) (Туре	, Print)				-			11

State of Maryland / Department of Health and Mental Hygiene 200527808 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August **Physician** 2005 Albert 5:20 am Alice /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 TF 571-70-8768 96 Director Sept. 28, 1908 Kentucky Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow 1 ☐ Yes 2 ☐ No Director MDAnne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Items 23a or Examiner must be 2106 River Crescent Dr. 21401 United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3XDWidowed 4 □ Divorced Year or Dates White "natural". in then "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file timent of Health and Mental Hy tent: If Itam 27 le marked oth jury or other traumatic event Be **Black** Betty Mae Heely ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Albert 124 Bryan's Channel Way Queenstown, MD 21658 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
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once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 2005 * 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory Alexandria, VA. 22. Name and Address of Facility Advent Funeral & Cremation Ser 21. Signature of Funeral S M00982 42 Hudson St. Suite 110, Annapolis, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMENTIA **Physician** resulting in death) /Medical ue to (or as a consequence of) Examiner Vascular isease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has lirector, page 2 autopsy performed? 250 No 1 Yes 2 🔁 No 1 🗆 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours are
To the Funeral Dir To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wlolly 24768 30. Name and address of person who completed "ause of death (Item 23a) (Type, Print) William A. Dabbs, Jr., M.D. 277 Peninsula Farm Rd. Arnold, MD. 21012 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

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Sattimore, Maryland bernit. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: if Item 27 is marked oth my inty no other traumatic event.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Removal from State	cemetery, crer	sition (Name of natory or other place		Date -2005		City or Town, State
Baltimor permit. Pages Department of I Important: if its	SUC#	21. Signature of Funeral Service Licens	A		Name and Addre	ss of Facility	N & NEWNA	HESTERTO	AT. HOME. P.A.
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JIVISION or Attending after death. Director: After in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	(v)	-		28f. Location (Street and Number	or or Rural Route Number,
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To the I within 2. To the I complet	₹	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
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		30 Name and address of person who co	ompleted cause of death (Iter	7 23a) (Type,			1	nagu	J. J. 400J
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State of Maryland / Department of Health and Mental Hyginal [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer MICHAEL ALLEN BENSON AUG 2005 10 2:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 15,1965 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 472-94-7679 40 Yrs. Director MN Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23s or 28s-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits ed other than "natural", or items 23a or 28a-f ahovevent, the Modical Examiner must be notified at 1 ☐ Yes 2 🛣 No Directo Chittenden Colchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 05446 157 Blakley Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritaf Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norma J. Russell Bernard A. Benson ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Benson/Wife 157 Blakley Rd, Colchester, VT 05446 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Dunial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 8/17/05 5 Other (Specify) Belvedere Cemetery Belvedere, VT 2. Name and Address of Facility 21. Sig ature of Funeral Se 22203 Robert J. Murphy Funeral Home 4510 Wilson Blvd, Arlington, VA 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** BLAST INJURY OF THE HEAD /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţoţ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) signed by Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation AUG 2 2005 UNKNOWN ™ 1 Yes 2 □ No COMBAT 2 Accident the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4X Homicide BATTLEFIELD IRAQ within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0101054497 (VA) Ang. 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY

State Registrar 31. Date filed (Month, Day, Year) AUG 1 2 2005

ELIZABETH A. ROUSE



ROCKVILLE MD 20850

State of Maryland / Department of Health and Mental Hygiene 05 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 1900 Sallie Bynum 2005 /Medical August 6. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Community Hospital Cheverly
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Director 240-36-6058 81 Nov. 18, 1923 Denmark, S.D. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menlal Hygiene. Int If item 27 is marked other than "natural", or Items 23e or 28e-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rat, or Itams 23a or 28a-f shov Exsmirer nust be nutified at Maryland Prince Georges Completed by Funeral Director Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9712 Wyman Way 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Black. traumatic avant, the Madical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Daniel Bynum Toppsie Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danny Bynum / Son 9712 Wyman Way Upper Marlboro, Md. othar 20b. Place of Disposition (Name of cemetery, crematory or other pla Harmony Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Aug.12,2005 Landover, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. 20747 1701085 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA CARDIAC Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 V No Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 [™] Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and tylie 29c. License number 29d. Date signed (Month, Day, Year) D51242 8-9-05 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KETH BONIFACE HOSPITAL 3001 32. Registler's Signature AUG 1 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 205Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 8°, 2005 Phyllis Brathwaite August 5:27 am 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Future Care Pineview Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8 - 7 - 1 9 2 1 Birthplace (State or Foreign Country) 5. Social Security Number Deys 1 ☐ M 2 🔀 F 059-68-3629 84 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD PG Upper Marlboro 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 11015 Pompey Dr. Panama 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐XNo Specify: 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas н. Payne Alberta Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17928 Cottonwood Terr., Gaithersburg, Hubert Thomas/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition tCIBurial 2 ☐ Cremation 3 ☐ Removal from State 8-12-05 Clinton, MD Resurrection Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Taylor's Funeral Home 21. Signal of Funeral Service Licensee 1722 North Capitol St. NW Washington DC deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter the disease, or complications that caused the shock/or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOPULMOHARY Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of Injury 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1[X Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier MO

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Registrar

Physician

/Medical

Examiner

Director

Funeral

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Physician/Medical Examiner

Certification: To Be Completed by

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and Mental Hygiana.

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Physician

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Saltimore, Maryland 21215-0020

State

of person who completed cause of deeth (Item 23e) (Type, Print)

TOR ONYSUAKA 7325A HAMOVERPARKWAY GREENBELT MARYLAND 2070S

31. Date filed (Month, Day, Year)

AUG 1 1 2005



State of Maryland / Department of Health and Mental Hygie	n	0	5

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7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygie 1 15 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2005 1828 5 August Charles E. Barnes 4c. County of Death

Months Days

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Cheverly

Prince George's

Birthplace (State or Foreign Country)

Physician	
/Medical	
Examiner	

4a. Facility Name (If not institution, give street and number)

5. Social Security Number

Prince George's Hospital

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or Items 23s or 28s-f show any injury or other traumatic event, I'm Medical Evaturinar must be notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

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Idm											Was an autopsy performed?	prior 1 death	autopsy findings available to completion of cause of i?
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o Be	25. Was case reference examiner?		Hospital:	Inpatient 💥	ER/Outpa	tient 3 🗆 🗅	Oth		ce of Death			6 ☐ Other (S	necht)
	27. Manner of Dea			of Injury of, Day Year)	28b. Time	e of	28c. Injur Wor				ribe how inju		pecny
tol	1 Natural 2 Accident	5 🗌 Pendi invest	ing (Mo tigation	ntn, Day Year)	Injur	М		κ? Yes 2[□No				
ertifica	3 Suicide 4 Homicide	6 🗌 Could deten	minod 200, Flat	e of Injury - At ho ding, etc. (Specif	ome, farm, y)	street, facto	ry, office				ion (Street a or Town, Stat		Rural Route Number,
Medical Certification:	29a. Certifier (Check only one)		ing Physician: To the										
Med	29b. Signature an	d title of certifi		inioi sialou.		2	9c. Licens	e number	r		29d. D.	ate signed (Mo	onth, Day, Year)
	· M	leal ne	1 Con	~	m	2	000	52-	2001		8	-5-0	25
	30. Name and add	drags of person	n who completed car	use of death (Item			11.	11	10	h.	1		25 np 20195
	WPA	bell	PIDISE			3001	1109	Pila	121,	ve,	Chev	es14. n	10 20785
	31 Date filed (Mo	onth. Day. Yea.	r) / 324	Registrar's Signa	ture							1	

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 1 2005

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 6 2005 1:00 A ANNA MAE BRITT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charles 3424 Peerless Place Bryans Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 ☐ M 2 💢 F Yrs Director 65 579-50**-**7376 June 12, 1940 Washington, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Bryans Road MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e U.S.A. 20616 3424 Peerless Place death v Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married õ 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ♥ Widowed 4 Divorced "neturel", White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service 9 Waitress other treumetic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental I Pages 1 and 2 should be Dorothy Stevens ပ Walter Gheen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I P.O. Box 1154, Bryans Road, Maryland 20616 Evelyn G. Britt, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If eny injury or once. ō Fort Lincoln Cemetery 08/10/2005 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Jas 4739 Baltimore Avenue, Hyattsville, Maryland tonslance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 🏋 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Atrial Fibrillation 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2X No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ar 2005 ъ 08

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

102 Paul Mellon Court #102, Waldorf, Maryland Ashvin J. Patel, MD AUG 1 1 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 5

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					State of Ma	arylariu /		tificate of	Death	weman ny	Reg. No.	י כו	21010
r	Physici	an	1. Decedent's Name	(First, Middle, Las	et)	-				2. Date of De Month	eath Day	Year	3. Time of Death
*	⊸ Physici /Medio		· · · · · · · · · · · · · · · · · · ·		BRAVO-REY	ES			4b. City, Town, or	08	06	y of Death	1945HRS
No.	Examir	ier		-	street and number)							e Geo	raola
			Prince Ge		ospital _{ex 7.} Aq	e (In yrs. last bi	irthday)	if Under 1 Year		8. Date of Bi			ace (State or Foreign try)
	Funeral Director		None Usual Residence of	1	□м 2ХД F		Yrs.	Months Days	Hours Min.	Aug. 5,	ay, Year) 2005	Mary]	
	ter death with the Maryland flems 23e or 28a-f show iner must be notified at	5	10a. State	10b. County		10c. City, Tov			-			10	0d. Inside City Limits 1∏ Yes 2 □ No
	28a-1	Director	MD 10e. Street and Nurr	Prince G	eorge s	DIAU	ensu	10f. Zip Code			10g. Citizen of	What Count	try?
	3e or		5415 Taus					20710	1		U.S.	Α.	
	death	Funeral	11. Marital Status	SSIE ROAU	12. Was Decedent Armed Forces?		13. W		dispanic Origin? (S an, Mexican, Puer	specify Yes or No	o- 14. Ra	ce - America	
Maryland 21215-0020	72 hours efter death with the Maryland naturel; or flerre 23e or 28e-f show dical Evantiner must be notified at	by	1 X Never Marrie	ed 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:			Yes 2□ No			Speci	fy:	ican
20	72 ho	ted	(Sneci	15. Decedent's Ed	ucation de completed)	16a	. Decede	ent's Usual Occup	pation during most of wo d)	rking	16b. Kind of E	Business/Ind	lustry
121	within ene.	Completed	Elementary/Secon		College (1-4or 5	5+)	life. D		d)		7/		
12	filed w Hygier ther th	8	n/a 17. Father's Name (Eiret Middle I act)				n/a	18 Mother's Na	me (First, Middle	n/a		
anc	8 ta 8 s	o Be								la Reye			
<u> </u>	should and Men merke umetic	۲	Celso Lu:		Type, Print)	19	b. Mailing	Address (Street	and Number or R				Code)
	d tra		Celso Lu	is Bravo,	Father	5	415	Taussig	Road, B1	adensbu	rg, Mar	yland	20710
ē,	es 1 en of Heal f item 2 r other		20a. Method of Disp	osition		20h Place o	of Dispos	ition (Name of atory or other pla		Date	20c. Location		wn, State
Ē	Pages nent of int: if its ary or o			□Cremation 3 □ 5 □Other (Specif)	Removal from State ()	Semen	teri	o San Be	rnardo	08/14/05	Pueb.	La, M∈	exico
Baltimore,	permit. Depertminimports any inju		21. Signature of Fur	Service Licen	stee _		22.	Name and Addre	ess of Facility Ga	sch's F	uneral i	iome,	P.A.
(11)	80 E 2 9	İ	Valu	wil how	Tree 110	01879			imore Ave			le, Ma	ryland
		П	23a. Part1. Enter the shock, or hear	ne disease, or comp rt failure. List only	ofications that caused one ceuse on each li	the death. Do	not ente	r the mode of dyi	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (I	Einel	Λ.	1 1 1 1		~~^^ A	1 4	101	00110	-	Onset and Death
	/Medical Examiner		disease or condition resulting in death)	n n	a. //	LIN	0/	VIII	7 110	EMOT	CKITT	146	
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	icete be executed physician and s the buriel-transit	Examiner	Sequentially list cor	nditions.	b	Due to (or as a	consequ	ience of):	1/			1	
0	ificete be executed g physician and es the bunel-transit		Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	mediate rlying	. PE	721	NA	177	e l	JEIN	LESS	on	
68760,	sete b ohysic the b	edicai	that initiated events resulting in death) L	ast	. /	Due to (or as a							
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P.O.	the d	Physician/M	Part II. Other algnin	cant conditions co	ontributing to deeth b	ut not resulting	in the un	derlying cause gr	venin Pait i.		Yes 27 No	3 □ Prot	
	s that				1						• • • • • • • • • • • • • • • • • • • •	_	
Vital Records,	The law requires that the death cert ste has been signed by the attendin page 2 should be deteched for use	Completed by									s an autopsy ormed?	ava	ore autopsy findings allable prior to appletion of cause death?
æ	sician: The law certificete hes t lirector, page 2 s	E								+0	Yes 2X No	1]Yes 2□No
ita		Be C	25. Was case referr	red to medical						ath (Check only	one)		
of <	> .00	2	1 ☐ Yes 2	No	Hospital: Inpatie	-		3 DOA		fome 5□Res			<i>'</i>)
ouo	D 5 6	tlon:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	n 5 □ Pending investigation	28a. Date of Inju (Month, Da		Time of Injury	M 1	nyat ork?]Yes 2⊡No	28d. Describe	how injury occu	Irred	
Division	i or Attendi after deeth. Director: A d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	280. Place of Inj	jury - At home, f c. (Specify)	arm, stre	et, factory, office			(Street and Nun own, State)	ber or Rura	l Route Number,
u	To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af completely filled in by the fu			1 Certifying Ph	ysician: To the best niner: On the basis o	f examination e	je, death nd/or inv	occurred at the ti	ime, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) and n	nanner as st , and due to	ated. the cause(s)
	thin 2 the F mplet	Medical	one) 29b. Signature and	title of certifier	and minner st	aran		29c. Licen	se number		29d. Date şign	ed (Month, i	Day, Year)
	OT WELL			Land	u Xv	Harl?	\	1	1627	9	8/6/1	5	
0	(2)		30. Neme and addre	ess of person who	completed cause of c	death (Item 23a)	(Type, F	Print)			3/0/0		111.
L	8	_ [ANTI	OINE	K. FON	Ufor)	M) . 3	001 H	SP DI	LIVE, Ch	every	, ald-20189
	Sta	ate	31. Date filed (Mont			rar's Signature	-						
	Regist	rar	AUI	G 1 1 200	The same	. #	1000	(e)					

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		1-	For State Registrar	Ciaic of N	iai yiana i		rtificate of		Memarry	Reg. No.	.003	21011
	sician		Decedent's Name (First, Middle, I	Eileen	Beeman				2. Date of De Month Au	path Day gust 10,	2005	3. Time of Death 9:15 P. M
	edical miner		Facility Name (If not institution, St. Vince	nive street and number ent de Paul Nur	sing Cente	er	4b. City, Town, o	or Location of Dea Fros			County of Death	
Fune Direct		5. 5	Social Security Number 215-14-6138	Sex 7. A	ige (In yrs. last 84	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	1. (Month, Da		9. Birthp	place (State or Foreign
land bw	i i	10	ual Residence of Decedent a. State 10b. County		10c. City, T	own or Lo	ocation					0d. Inside City Limits
he Mary 18a-f sh	ector	1		llegany				Lonaconing	3			1 ☐ Yes 2 🕅 No
th with t	ai Dire	106	a. Street and Number	osevelt Way			10f. Zip Code	21539		10g. Citiz	ten of What Cour U.S.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Musical Examiner must be muiting a	by Funeral Director	11.	Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Deceden Armed Forces 1 Yes 2 K If Yes, Give Year or Dates	? No		Was Decedent of H If Yes, specify Cubin 1 Yes 2 No	tispanic Origin? (an, Mexican, Pue Specity:	Specify Yes or Norto Rican, etc.)		4. Race - Americ Black, White, Specify:	ean Indian, etc. White
72 hg	eted		15. Decedent's (Specify only highest of		1	6a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of w	orking	16b. Kin	nd of Business/In	dustry
212 d withir giene. rr than	Completed	- 1	Elementary/Secondary (0-12)	College (1-4or	5+)	life.		omemaker			Hon	ne
land id be filed ental Hyg	To Be C	17.	Father's Name (First, Middle, La	William Jone	es			18. Mother's Na	ame (First, Middle	. Maiden S ulia Wa	Sumame) alters	
Maryland 21215-0036 and 2 should be filed within 72 hours att alth and Mental Hygiene. 27 is marked other than "natural", or freatmatic event, the Medica Exami			a. Informant's Name/Relationship Sandra Fletcl	(Type, Print) ner - Sister	1	9b. Maili	ng Address (Street		Rural Route Numb			Code)
Baltimore, Dermit. Pages 1 a Department of Hez Important: If item			a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec			etery, crei	sition (Name of matory or other plac t Memorial Pa		Date August 15, 2005	20c. Loc	cation - City or To Cumberlar	
bermit. Departr Imports	SUCE	21	Signature of Funeral Service Lie	/			Name and Addre	,	l Home 8 Eas	t Main	St., Lonacon	ing, Md. 21539
/Medic Examin	al	Im dis res	ia. Pánfi. Enter the disease, or constock, or heart failure. List on mediate Cause (Final sease or condition sulting in death) quentially list conditions, ny, leading to immediate the conditions of the conditi	a. Due to (or a	s a consequences a consequences	ce of):	0	ng, such as cardia		rrest,		Approximate Interval Between Onset and Death 3 m on this
I RECORDS, P.O. BOX 68/6U, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF	FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No		e of pregnancy 2 Petal death		Ectopic pregnancy	/		2:	3d. Date of delive	ry Day Year
hat the d ed by the detached	hys	-	9 Unknown	9□ Unknown								
w requires that been signed should be del	Š	1 "	t II. Dther significant conditions	contributing to death	but not resulting	g in the u	nderlying cause giv	en in Part I.		obacco us Yes 2		e cause of death? ably 4 Unknown
VITAI KECOFGS, iician: The law requires ti certificate has been signe rector, page 2 should be c	Completed		Wee need to real to realize						24a. Was autor perio 1 Yes	rmed?	prior to con death?	osy findings available apletion of cause of 2 1
g Phys gerthis	ion: To Be	L	Was case referred to medical examiner? 1 Yes 2 No Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpati 28a. Date of Inj (Month, Da	ury 28t	Outpatien Time of Injury	28c. Injun Work	er: 4 Nursing l y at k?	Home 5 Resident Resid	dence 6)
LIVISION OI Hospital or Attending Phys 4 hours after death. Funeral Director: After this tely filled in by the funeral di	Certification:		2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Ir	ijury - At home, tc. <i>(Specify)</i>	farm, str	M 1 D	Yes 2 □ No	28f. Location (S City or Tox	Street and vn, State)	Number or Rura	l Route Number,
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical		a. Certifier (Check only one) 1 Certifying F 2 Medical Ex	Physician: To the best aminer: On the basis of and manners	of examination	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
To the To the Comp	ž		b. Signature and title of certifier	000			29c. License			29d. Date	signed (Month, L	Day, Year)
		30	Name and address of person wh	Koffen	death (lto= 00)	MD	DOG	05532	5	Au	g-11,20	005
5			WONSOCK SH	IN MD	487		Print)			MD	21532	
	State strar	31.	Date filed (Month, Day, Year) AUG 1 5	2005 32. Regist	rar's Signature	- 23	1 100 -		0			

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			Registrar			Cel	uncale of	Deam		Reg. No.			
E.	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of De		Year	3. Time of Dea	ath
	/Medic			Ве	enjami	n Bar	r		AUG.	8. 200		2152	DM
	Examin		4a. Facility Name (If not institution UNIVERSITY HOS	n, give street and number) PITAL)			r Location of Death ORE CITY	1100	-,,	nty of Death		₽
	Funeral Director		5. Social Security Number 234-35-4882	1/XM 2□ F	ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Col	npiace (State or Fo untry) Virgini	
7	2	-	Usual Residence of Decedent		1								
Manda	atter usatir with the marylar or items 23s or 28s-f show	ctor	10a. State 10b. County Maryland Frede	erick		Town or Lo	cation					10d. Inside City L 1 ☐ Yes 2 [
di di	a or 28	Director	10e. Street and Number			220011	10f. Zip Code			10g. Citizen o	of What Cou	intry?	
4	23	ra	4531 Jefferson 1					755		Unite			
9		Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	o- 14. R	ace - Amer	ican Indian,	
တ္က နိ	72 hours "natural", dical Exa		1 X Never Married 2 Marr	No 1 ☐ Yes 2 ☑ No Specify:							, 810.		
8		l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 1 1 9 2 Z Z 1 1 1 0	зреспу.		Specify: White			
15-0		letec	(Specify only highe	t's Education st grade completed)		16a. Deced	dent's Usual Occup	ation during most of work 1)	ing	16b. Kind of	Business/I	ndustry	
21215-0036	7 70 = -	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	m 6. I	Student	1)		S	choo1		
1d 2	, O E	d)	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle	, Maiden Sum	ame)		
Maryland	th and Menta 7 Is marked trsumatic ex	To B	Roy Lester					Nancy C.	Barr				
<u>a</u>	Dua min		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Run	al Route Numb	er, City or Tow	m, State, Zi	p Code)	
- 0	- 0 -		Nancy C. Cantre	11/ Mother		4531	Jefferson	n Pike, J	efferso	n. Mary	vland	21755	
Baltimore	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	Cer	netery, cren ropoli	sition (Name of natory of other plac Ltan Crem	8/11/ atorium I	2005	Alexan	n - City or T dria,	own, State Virgini	a
Bal	Department Department Importent: If any Injury of once.		21. Signature of Runeral Service	Menu	/	20	9401 Klag	ss of Facility lesworth e Road, D	amascus	Funeral Mary	Home		
2	hysician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each li		Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Deat	h
1100	Madical		resulting in death)	a. L.IU	15	100	1						

/Medical Examiner

physician and s the burial-trans

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical 25. Was case referred to medical examiner? Be P Certification: 27. Manner of Death

Medicai

1 Yes 2 □ No

5 Pending

investigation

6 Could not be determined

1 📮 Natural

2 Accident 3 Suicide

4 Thomicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed

cate has l

After this funeral of

after death Director:

within 24 hours a To the Funeral I

death.

Division of Vital Records, P.O. Box 68760,

Muchile Due to (or as a consequence of): Dualti for as a consequence of) Due to (or as a consequence of)

IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal de 23b. Was decedent pregnant 2 Fetal death in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Dav

AUG.

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 es 2 \sum No

or Bural Route Number

10, 2005

Year

26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 XER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

10:\ 8 M 1 = 1 ☐ Yes 2 🗙 No Place of Injury - At hor building, etc. (Specify,

28f. Location (Street and Number City or Town, State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner is smited. 29a. Certifier The definition of the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as a ned.

227 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

30 Name and address of person who completed croce of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

TOLKIN PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year) AUG 1 2 2005 ar's Signature

State of Maryland / Department of Health and Mental Hygiene 2005 27819 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MXTG 5 2005 **Physician** TERRY WAYNE BALL 10:39 AM .TR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY **BETHESDA** NATIONAL NAVAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) SEPT. 9, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 1**∑**M 2□ F ILLÍNOIS 36 Director 361-60-1378 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State Items 23a or 28a-f show the Mudical Examiner must be notified at 1 □XYes 2 □ No Director ONSLOW JACKSONVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 106 BALDWIN CT. 28546 U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1989-11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If tiem 27 is marked other then "natural", or Italiany injury or other traumatic event, the Modical Examinations. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify: þ 3 Widowed 4 Divorced WHITE 2005 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Continue of the continue of the 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **DEFENSE** 12 U.S. MARINE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SHARON SUE TERRY WAYNE BALL SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 BALDWIN CT., JACKSONVILLE, NC 28546 **JENNIFER** BALL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) ARLINGTON NAT'L. CEM. 8-19-2005 ARLINGTON, VA. 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P. A. 21. Signature of Funeral Service Liperises Chambella 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final COMPLICATION OF BLAST AND SHRAPNEL INJURIES **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of). Box 68760. iding physician Physician/Medical the 35 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No O 9 Unknown þ ۵ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ACUTE ABDOMINAL HEMORRHAGE DUE TO PEG PLACEMENT 2 🗗 No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of degth?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 X perf 1 ☐ Yes 2 🗆 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Hospital or Attending 5 Pending investigation 1 Natural after death.

I Director: Aff JUN 12 2005 UNKNOWN™ 1 No Yes 2 No COMBAT 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide BATTLEFIELD IRAO within 24 hours the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) ^{29c. License number} 227359 (NY) 29b. Signature an 101 August 8, 2005 9+1 ARMED FORCES INSTITUTE OF death (Item 23a) (Type, Print) 30. Name and address of person who comple PATHOLOGY, ROCKVILLE MD Maj USAF MC DZUY T. NGUYEN 20850 31. Date filed (Month, Day, Year) 33 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygie 05

3. Time of Death

8/8/05

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show many injury or other treumatic svent, the Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	KATHERIN			RRETT				AUG.	6,		005	3:35	P
4a. Facility Name (If not insti					4b. City, Town, o	or Location	of Death		4c.	County	of Death		
HEARTLAND		ARE CE	NTER			TTSVI			P	RIN	CE GE	ORGES	
5. Social Security Number	6. Sex 1 ☐ M		ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of 8	lirth Day, Year)		9. Birthp	lace (State try)	r Fore
419-30-5328		2 X	75	Yrs.				AUG.		29_		NKNOW	
Usual Residence of Decede 10a. State 10b. Co			10c Cin	y, Town or Loc	nation								
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	NCE GEOR	GES	1		BELTSV	ILLE						1 X Yes	2 🗆
10e. Street and Number					10f. Zip Code				10g. Citi:	zen of V	Vhat Cour	try?	
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11. Marital Status		Vas Decedent			Vas Decedent of I	Hispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	10-		e - Americ k, White,		
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3 Widowed 4 □ Div	orced Y	ear or Dates:	UNK.			5,55,				Орвспу	WHI	TE	
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12					UNKNO	WN					JNKNO	WN	
17. Father's Name (First, Mi	ddle, Last)					18. Moth	er's Nami	e (First, Middi	le, Maiden	Sumam	10)		
	UNKNO	WN						U.	NKNOW	N			
19a. Informant's Name/Rela	itionship (Type, F	Print)		19b. Mailin	g Address (Street	and Numb	er or Run	ai Route Num	ber, City or	r Town,	State, Zip	Code)	
ANNA R. NEWI	PORT/FRI	END		3128	CHRISTIN	E DR.	, BE	LTSVIL	LE. M	D. 2	20705		
20a. Method of Disposition				lace of Dispos	sition (Name of natory or other pla			Date			City or To	wn, State	
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	- wind	1000	TIOU		U/IT / T L U/			11 . 17				11/3/	
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Immediate Cause (Final disease or condition	List only one ca	use on each	ed the death line.		er the mode of dyi			., RIV		E, F	ш. Z	Approximat	ween
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State Registrar MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH K. MUTTATH, M.D.

31. Date filed (Month, Day, Year) AUG 1 1 2005

D0058290

4203 QUEENSBURY RD., HYATTSVILLE, MD. 20781

JD:	549	_	1 - State Amend Item 1&U	State of Maryl Inpend Item						
	Physicia /Medic		negistrar Decedent's Name (First, Middle, Last) Charles Thomas Bli:					2. Date of Death		3. Time of Death
	Examin		4a. Facility Name (If not institution, give st Frederick Memorial	Hospital		Frederi				ick County
	Funeral Director		5. Social Security Number 6. Sex 213-78-0544 XX Usuel Residence of Decedent	7. Age (In 48	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06/28/5	9. (Year) 9. (Year) 9. (Year) 9. (Year)	Birthplace (State or Foreign Country) ID
3	Maryland -I show	tor	10a. State 10b. County MD Frederic		: City, Town or Lo Frederick					10d. Inside City Limits 1 ☐ Yes 2 No
	n with the	al Director	10e. Street and Number 414 Sherman Ave			10f. Zip Code 21701			g. Citizen of Wha	at Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury og other traumatic event, the Madical Examinations to notified at once.	by Funeral		2. Was Decedent Ever Armed Forces? XX Yes 2 \(\text{No}\) No XYes, Give Year or Dates: 197		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Thite
Baltimore, Maryland 21215-0036	within 72 ho ine. Ihen "natur ie Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done on DO NOT use retired	furing most of work	ing	6b. Kind of Busin	ness/Industry
land 2	uld be filed v fental Hygie rked other t tic event, tt	To Be Co	17. Father's Name (First, Middle, Last) Charles Thomas Bli	zzard, Sr.	THE	Jec 201		e (First, Middle, M Mae Smit	aiden Sumame)	
Mary	ind 2 shou alth and M 27 ie mai er traumal		19a. Informant's Name/Relationship (Type Alicia M. Carey/Da			ng Address (Street a Γripatoe			City or Town, Sta D 21758	
imore,	Pages 1 annent of Herant: If item		20a. Method of Disposition 1 ★ Qurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	ob. Place of Dispo cometery, cre Restnaver	osition (Name of matory or other place Cemeter			oc. Location - Cit rederick	-
Balt	permit. Departr imports any inj		21. Signature of Funeral Service Ligense	M0095	56 Re	501 Catoc	Funeral S tin Mtn.	Hwy., Fre	derick,	
	Physician /Medical		23a. Part1 Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Atheroscle Due to (or as a col	rotic Ca				st,	Approximate Interval Between Onset and Death
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury	Due to (or as a con						:
<u> </u>	te be executed ysician and he burial-transit	ical Examiner	that initiated events cresulting in death) Last	Due to (or as a co	nsequence of):					
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of Month	
	quires that t n signed by uld be deta	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	underlying cause giv	en in Part I.			ute to the cause of death?
Division of Vital Records,	a 2 CA	Completed				·		24a. Was ar autops perform 1 X Yes 2	prio ned? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 \(\text{No} \) No
' Vita	ysician: s certifici director,	To Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	ospital:	2 X ER/Outpatie	nt 3□ DOA Oth	00	th <i>(Check only one</i>		(Specify)
ion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	atlon; T	27. Manner of Death 1 Manner of Death 1 Manner of Death 1 Manner of Death 1 Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	tal or Atters after de sel Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	treet, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifying Physic (Check only one)	sician: To the best of more: On the basis of exa and manner stated.	amination and/or in	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	rred at the time, da	ite and place, an	d due to the cause(s)
)	1	2	29b. Signature and title of celtifier	~ /	N	29c. Licens	Œ		August 1	
	*		30. Name and address of person who co	mpleted dause of death	ı (Item 23a) (Type	111 Penn	Street	Baltimore	e, Maryl	and 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 2 20	32. Registrar's	Signature	me				

State of Maryland / Department of Health and Mental Hygier 15 27822 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Frances Clark AUG. 2359 Bryson 8 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 312/3/14 REGIONAL MEDICUL KENINSULA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗙 F Months Days Hours Vrs Director 225-70-0630 87 7/4/1918 Texas Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21804 1103 S. Schumaker Dr., Apt. 309 USA Items 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r illed within Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman Kelly Clark Everald Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 1103 S. Schumaker Dr., Apt 309, Salisbury, MD 21804 Robert P. Bryson/husband other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o once. 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State
14 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 8/9/05 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 nature of Funeral Service Licensee David CFSP Composit 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Althero 3 clevolic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of a the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospitel or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death. 1 Tyes 2 No 2 Accident the 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medical within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D54127 mo G 30. Name and address of person who completed chuse of death (Item 23a) (Type, Print) Salisbury 100 Power Street lan DAMS 32. Paistrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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death

filed within 72 hours after

Pages 1 and 2 should be

or Attending Physician: The law requires that the death certificate be executed

the Hospital

.O. Box 68760.

Division of Vital Records, P.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department / De 27823 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Bri anna Orlenzia Audrey Braxton August 14 2005 1023 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 219-71-4094 Yrs. Director Feb. 9, 2005 Md Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Mode 1 Yes 2 □ No Wicomico Directo Md. Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 rel', or items 23a or Examiner must be 675 Main st. apt.#2 21801 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □XYes 2 □ No Black Specify: ð 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed other then "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 never worked infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Brian Orlenzia Braxton Ursula Rose Holbrook ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 675 Main st apt.#2 Salisbury, Md.21801 f Health a Ursula R. Holbrook/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 □ Burial 2 □ Cremation 3 □ Removal from State Metropolitan Ceme, 8/23/05 Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal fre of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella st. Salisbury, Md. 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Head Injuries Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit Exami resulting in death) Last Due to (or as a consequence of): physicien s the burial by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy lindings available prior to completion of cause of death?

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Yes 2 □ No 24a. Was an certificete hes l irector, page 2 s autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred
Passenger in Moter Vehicle 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 3:37 1 Natural 8-11-05 Рм 1 Yes 2 No Director: / 2 Accident 3 | Suicide Collision 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) Jersey Rd. &Connelly Mill Rd. Salisbury, Md within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Roadway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME August, 15, 2005 KOM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD III Penn St. Baltimore, MD

State

31. Date liled (Month,

Day, Year)

AUG 2 2 2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Ward Beckman AUGUST 20, 2005 6:25A. Russell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hospital & Medical Center Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug 14, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1⊠M 2□F MD 723-14-5609 1928 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at MD Allegany Cumberland 1 Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code ŏ 21502 12810 loka Drive USA Items 23a death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc filed within 72 hours after I ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white ŏ Baltimore, Maryland 21215-0036 Specify 3 ₩ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plastic Division O'Sullivan Corp. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hy tant: If item 27 is marked oth Be Grace (Moon) Beckman Tichnell Albert Beckman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Huff daughter 12810 loka Drive Cumberland MD 21502 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. Rocky Gap Veterans' Cemetery 8/23/2005 MD Flintstone ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Sign sture Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Asystole 12 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, as the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, physician by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes Coronary artery disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier t 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number D58853 AUGUST 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Pennsylvania Avenue, Cumberland, MD 21502 Dr. Habib Chotani,

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2

2005

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32. Registrar's Signature

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State of Maryland	/ Department of Health and Menta	I I Iyyichid	U	J	_

		For State Registrar	State of Maryland	/ Departmo Certific				gie z ie) () 5	21825
Physic /Med		1. Decedent's Name (First, Middle, Last) ELEANOR	LOWISE				2. Date of Dea Month	5T 00 200	0210 YM
Exam		4a. Facility Name (If not institution, give s Washington County	Hospital		Hage	r Location of Death		4c. County of De	ngton
Funera Directo		5. Social Security Number 6. Sex 577/16/4174	7. Age (In yrs. last	t birthday) If Ur Yrs. Mont	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day August		irthplace (State or Foreign Country) Maryland
Maryland f show	lor	10a. State 10b. County Maryland Washingt		Town or Location	thsbu	rq			10d. Inside City Limits 1 ☐ Yes 2 No
with the 3a or 28a	Direc	10e. Street and Number 13625 Edgemont Roa			Zip Code	783		10g. Citizen of What	·
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiena. Ind thygiena. Ind other than "natural", or Itams 23a or 28a-f show evant, the Medical Evanther must be inclified at evant.	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		ecedent of H specify Cuba s 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. White
Maryland 21215-0036 nd 2 should be filed within 72 hours att the and Mental Hygiena. 27 is marked other than "natural", or traumatic event, the Medical Event traumatic event, the Medical Event.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	life. DO NO	work done T use retired	during most of work d)		16b. Kind of Busines	
yland 21 vould be filed w Mental Hygier mrkad other ti	To Be Col	17. Father's Name (First, Middle, Last) William H. Bowmar		Administ	rativ			Educati Maiden Sumame) an	.on
	F	19a. Informant's Name/Relationship (Ty, Harry D. Catts (Sc		•				r, City or Town, State	
timont of trant: If I		20a. Method of Disposition 1 Disposition 1 Disposition 2 Cremation 3 Repair (Specify) 21. Signature of Funeral Service License	emoval from State Imma	ce of Disposition (netery crematory CCUIate Cemeteru 22 Name	or other plac Concep	#ion	2005 st 23,	20c.Location-City(Fairfield) avis Fune	Pennsylvani
Dermii Depar Impo		23a Part. Enter the disease, or compli	Davis mol	41412525	Brad	bury Ave.	Smiths	burg, MD 2	
68760, Witcate be executed Examination and Street S	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause first fundarying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequent of the consequent of	nce of): TUN PN nce of): VASCU A nce of):		2022-1-1-1-1			Interval Between Onset and Death
Box 6 ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnanc 1 ∐Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3□Ectop	ic pregnancy (specify)	,		23d. Date of o	lelivery Day Year
ds, P.O. I juires that the de n signed by the a lid be detached i	þ	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the underlyi	ng cause giv	en in Part I.			to the cause of death? Probably 4 □Unknown
	Completed						24a. Was autop perto	osy prior t rmed? death	autopsy findings available o completion of cause of ? es 2 □ No
ling After	To Be	27. Manner of Death 1 Matural 5 Pending		R/Outpatient 3 (2) 8b. Time of Injury	DOA Oth	y at	ome 5 Resid	ne) dence 6 ⊡Other (S) now injury occurred	pecify)
Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)			755 2(3.15	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
he Hospit n 24 hour ha Funara	edical (sician: To the best of my knowle ner: On the basis of examination and manner stated.						
To the within To the Comp	W	29b. Signature and title of certifier Maham Muhi		1		1562		29d. Date signed (Mo	2005
	0	30. Name and address of person who co			MAD	MAU HU	MAKYL	AND 21	140
Regi	itate strar	31. Date filed (Month, Day, Year) AUG 2 4 2005	32. Registrar's Signatur	pole					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27826 State of Maryland / Department of Health and Mental Hygier 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Bosley Gay1e Verna August 15, 2005 1:15 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 21020 Brook Knolls Road Laytonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2 F Days Hours 220-58-1103 60 Yrs. 08/23/1944 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Cumberland MD Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11903 Knob Road, N.E. 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Smith Erdie Pauline Charles William Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11903 Knob Road, N.E., Cumberland, Maryland 21502 Rodney W. Bosley, Sr. / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lybarger Lutheran Cemetery 08/19/2005 Hyndman, Pennsylvania 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. alle 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) y RS Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 mgs Month Day 5 Other (specify) ☐Yes 2 🗷 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Beath 28c. Injury at Work? 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number D22181 August 16, 2005

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death.

Director: After this certifications

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification:

Physician /Medical

Examiner

the attending physician and shed for use as the burial-transit

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Madical Exercitival mast tentofiled at

Baltimore, Maryland 21215-0036

completely filled in by the funeral To the Hospital
within 24 hours a
To the Funeral D 3

Tran State

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

925 Bishop Walsh Drive, Cumberland, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary L. Wagoner, M.

AUG 1 6 2005

State of Maryland / Department of Health and Mental Hygien [] [] 5 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 8:35 **Physician** A M August 13, 2005 Sheila Bauer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 23008 Hopton Lane St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) June 22, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F 72 Yrs. 1933 Director 122-24-7032 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neart of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or iteme 23a or 28a-f ehow ury or other traumatic event, The Madical Examinar mant the inclining an 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Florida Fort Myers Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 33905 4690 Blackberry Drive, S.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking 12 Loan Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Richard Aloysius Fitzgerald Isabelle Marie Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23008 Hopton Lane, Leonardtown, Maryland 20650 Gregory J. Bauer / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State August permit. Page Department of Important: If any injury or once: 4 ☐ Donation 5 ☐ Other (Specify) Mount St. Mary's Cemetery 17, 2005 Flushing, New York 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** astalor disease or condition resulting in death) /Medical **Examiner** undederenne Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely fillad in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 1380 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John F. Fenwick, M.D. 22650 Cedar Lane Court, Leonardtown, Maryland 20650 31. Date filed (Month, Dan York) 1 5

State Registrar 32. Register's Signature

2005

/sicia		Decedent's Name (First, Middle, Last	State of Marylan per informant	Cer	incate of L	Jean	2. Date of Dea	ıth		3. Time of Death
ledic.		Howard Lee	Blair	•			Month August	Day 5, 200	Year 5	2:00 P
amine		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County		
		3216 Henderson A 5. Social Security Number 6. Se		last hirthday)	Wheaton If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		gome:	ry lace (State or Foreig
eral ctor			≱ M 2□F 71	Yrs.	Months Days	Hours Min.	(Month, Day March 2	Year) 4, 1934	Cour	lahoma
	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limit
	io	Maryland Montgom	ery W	heaton						1 ☐ Yes 2X N
one	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V		ntry?
	eral	3216 Henderson A	.venue 12. Was Decedent Ever in U	S 13 V	20902 Vas Decedent of His	spanic Origin? (Sp.	acity Vas or No-	US 14 Bac		an Indian.
	표	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ∰Yes 2 □ No	1	Yes, specify Cubar ☐ Yes 2021No	, Mexican, Puerto Specify:	Rican, etc.)	Btac	k, White,	etc.
	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates: 1953	,	lent's Usual Occupa	tion		16b. Kind of Bu		
	Completed	(Specify only highest grad		(Give	kind of work done d OO NOT use retired)	uring most of work	ing	TOD. PAILO OF DA	23110337111	addity
	Com	12		Power	Tool Rep			Remanu		uring
	Be	17. Father's Name (First, Middle, Last)	loim			18. Mother's Name		Maiden Suman	10)	
	2	William Edward B 19a. Informant's Name/Relationship (T)		19b. Maitin	g Address (Street a	Beulah		r. City or Town.	State, Zin	Code)
1		Wanda Ero/ Daugh	• • • • • • • • • • • • • • • • • • • •		Merle Way				-	,
,		20a. Method of Disposition 1 ☎ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, cren	sition (Name of natory or other place	n Augu	Date IST 10	20c. Location -	-	
١		4 □Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens			Name and Addres	200 s of Facility.				Maryland
ouc		I you I do	rerlo	57	ancis J. O Univer	Collins sity Blvc	Funeral	lver sp	nc ring	, MD 2090
. 8		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the deat	h. Do not ente	er the mode of dying	, such as cardiac	or respiratory an	rest,		Approximate Interval Between
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ı	Jer	if any, leading to immediate	Due to (or as a conseq		icy					MERKS
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l	al Ex	resulting in death) cast	Due to (or as a consequence Emphysema	uence of):						
	Medical	IF FEMALE:	u							
	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Il death 3 🗌	Ectopic pregnancy			23d. Dat	e of delive	ery Day Year
	iysic	1 Yes 2 No	4□Pregnant at time of d 9□ Unknown	eatn 5∟	Other (specify)					
	by P	Part II. Other significent conditions co	ontributing to death but not res	ulting in the un	derlying cause give	n in Part J.	23e. Did to	bacco use conti	ribute to th	ne cause of death?
							1 🗆 Y	es 2□No	3⊊ Prob	ably 4 Unknow
	Completed						24a. Was a autop	sy p	prior to cor	psy findings availabl mpletion of cause of
	1000						perfor 1 Tyes		death?	2 No
				FB/0-+	Othe	26. Place of Death			. (0	
	Be	25. Was case referred to medical examiner?	Hospital:		t 3□ DOA	4 Nursing Ho	me 5 Resid			/)
	To Be	examiner? 1 🖫 Yes 2 🗌 No 27. Manner of Death 1 🛣 Natural 5 🗍 Pending	28a. Date of tnjury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occurr		
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	Certification; To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 No 1 X Certifying Phy 2 Medical Exam	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specifications) ysician: To the best of my kno iner: On the basis of examina	28b. Time of Injury	28c. Injury Work M 1 T Year 1	at ? /es 2 \(\text{No} \)	28f. Location (S City or Tow	treet and Numb n, State) ause(s) and ma	<i>er</i> o <i>r Rur</i> a	ated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydie 2005 27829

				For State Registrar		State of M	ıaryıan		tificate			ientai Hy	Reg. No.	10	21023	
		Dhunisi		1. Decedent's Name (First,	Middle, Last	1)						2. Date of D	eath Day	Year	3. Time of Death	
		Physici /Medio				Charshe						Augus			10:30a	л
		Examir	ner	4a. Facility Name (If not ins			·)		4b. City, Tov	vn, or Loc	ation of Death			ty of Death		
				Union 5. Social Security Number	Hosp:		ge (In urs	last birthday)	E 1	kto	n Under 24 Hrs.	8. Date of B	Cec		place (State or Foreig	an.
		Funeral Director		212-26-436 Usual Residence of Decedence	53	M 21XIF	77	Yrs.			ours Min.	(Month, D	er 27,	Cou	ntry)	
		death with the Maryland sma 23s or 28e-f ehow if must be neithed at	_		County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limit	
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		with th	5	10e. Street and Number					10f. Zip Co				10g. Citizen of		•	
		a 23a	era	113 Mahoo	goney	Drive 12. Was Deceden	t Ever in II	S 13 V		901	nic Origin? (Sp	ecify Yes or N		S.A		
	36	urs after death with the Marylan al', or Itema 23a or 28e-f ehow Exeminet must be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 3-Widowed 4 Div		Armed Forces 1 Yes & If Yes, Give Year or Dates	?] No		Yes, specify		nic Origin? (Sp lexican, Puerto pecify:	Rican, etc.)	ВІ	ack, White, ify: Wh	etc.	
	5-00	72 hours "natural",	eted t	15. De	ecedent's Ed			16a. Dece	lent's Usual C kind of work o	ccupation	n ng most of work	ring	16b. Kind of	Business/Ir	dustry	
	Maryland 21215-0036	ig " 2 2	Completed	Elementary/Secondary (i	0-12)	College (1-4or	5+)		cress	etired)			Gran	Din	er	
2	pu	be filed wit ital Hygiens d other the	BeC	17. Father's Name (First, M	Middle, Last)					18.	Mother's Nam	e (First, Middl	e, Maiden Suma	me)		
Q	ylaı	should be nd Mental marked o imatic eve	To	Tillman	Boyc	e					Maude	e Long				
0)	lar	O4 00 00 00		19a. Informant's Name/Re				19b. Mailir	ig Address (S	treet and	Number or Rui	al Route Num	per, City or Town	n, State, Zi	o Code)	
2	e)	1 and 2 ; Health ar em 27 is		E11a Bende		ughter	20h F	25	Monti	cose		, E1kt	on, MI		921	
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Ī	Вох	eath certi attending for use a		IF FEMALE: 23b. Was decedent pregna	ant	23c. If yes, outcom			1c				23d. D	ate of deliv	rery	
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	is!	Atten r deat octor: by the	Certification;	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of le	njury - At h	ome, farm, str				28f. Location	(Street and Nun	nber or Rui	al Route Number,	
	Ö	s after	Sert	4 Homicide	_	building, e	etc. (Specif	<i>Y</i>)				City or 10	iwn, State)			
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filted in by the funeral director.	Medical C	29a. Certifier 1 Co (Check only one) 2 Me	ertifying Phy edical Exam	/sician: To the besiner: On the basis and manners	of examina	wledge, death	occurred at the control occurr	he time, o my opinio	date and place, on, death occur	and due to the	cause(s) and r , date and place	nanner as :	stated. to the cause(s)	
-		To th within To th compl	Me	29b. Signature and title of	certifier	1			29c. L	icense nu	mber		29d. Date sign	ed (Month,	* * * * * * * * * * * * * * * * * * * *	
				He	Q.	hos	_	~ NO		03	5721	0	Ang	, 12	2005	
-	. ,	7		30. Name and address of p	person who c	completed cause of	death (Iten	n 23a) (Type,	Print)	= 1						_
		J		31. Date filed (Month Page	en avario -	1072	7 Ch	//	D , F	H	-5					_
		Sta Registr	_	OT. Date filed (Month AU	5772 2	UU5 °2	rar's Signa	15 A	parti.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200527830 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Charles Cole 8:26 AM F, 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly
If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 93 Months Days Hours 081-32-7070 New York Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or than "neturel", or Items 23e or 28e-1 show the Madical Examiner must be notified at West Virginia Jefferson Harpers Ferry 1 □ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 68 Potomac Meadow Lane 25425 USA Funera 12. Was Decedent Ever in U.S. Armed Forces?

1. Aves 2 \(\text{No.} \) No 1933- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: δ 1963 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chief Warrant Officer U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) pernit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumetic event QDCS. Be Guy Cole Elizabeth Bremiller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28498 Flora Corner Rd., Mechanicsville, MD 20659 Joan Neill/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug 05 11 Charlotte Hall, MD 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Crematory ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licensee > Mibbly P.A., 30195 Three Notch Rd., Charlotte Hall, MD Approximate 20622 Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Troumatic Desin Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mortas Velville Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ₱No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 1 🗌 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) Certification: To this Truck 2 28d. Describe how injury occurred 28a. Date of Injury (Month, ay Year) 28b. Time of Injury 27. Manner of Death After or Attending 1 Natural 5 Pending 2005 9:39 AM 2 No death. 8 2 Accident investigation after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) South 5 20 West Ch Rord ST. Many's Count 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide STreet within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. \mathcal{M} 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 D4693 Cabriel E. Ryb, My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14+1 azolt 1008 Drive, Chauraly

Registrar

State

31. Date filed (Month, Day, Year)

AUG 1 2 2005

Elver & Speck

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygie 12 0 0 5

			For State Registrar	State of Maryland /	Certificate of I			3. No.	21831
	Physici /Medic		1. Decedent's Name (First, Middle, La: Dolly Evely:	n May Carrier			2. Date of Death Month Aug. 1:	2, 2005	3. Time of Death 7:30 p M
	Examin	200	4a. Facility Name (If not institution, giv. 12849 Lanes R		4b. City, Town, or Big Po	Location of Death		4c. County of Death Washingt	on
	Funeral Director		213-30-0349	ex	oirthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Mar. 8,	(ear) 9. Birthp Cour 1939 MD	place (State or Foreign htry)
	Maryland	tor	Usual Residence of Decedent 10a. State MD 10b. County Washine	gton 10c. City, To Big	own or Location Pool			1	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the	I Direc	10e. Street and Number 12849 Lanes Ru:	n Rd	10f. Zip Code 217	11	10	g. Citizen of What Cour	ntry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Itams 23a or 28e-f show may injury or other traumatic event, the Medical Exact restricted at Ance.	by Funeral Director	11. Marital Status 1 Never Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036	within 72 ho ene. then "netur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ducation de completed) College (1-4or 5+)	sa. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Homemaker	ation during most of workir 1)	ng 10	sb. Kind of Business/In residenc	
and 2	d be filed ental Hygi ced other c event. I	Be	17. Father's Name (First, Middle, Last, Silas Henry W.			18. Mother's Name Savann	,	abelle Mc	Cauley
Maryland	id 2 shoul Ith and Me 27 Is mark traumati	C.	19a. Informant's Name/Relationship (1	9b. Mailing Address (Street 2849 Lanes	and Number or Rura Run Rd.	Route Number,	City or Town, State, Zip	Code) 1711
Baltimore,	Pages 1 an nent of Heal nt: If item 2 iry or other		20a. Method of Disposition 1 Disposition 1 Disposition 1 Donation 5 □ Other (Specification)		of Disposition (Name of tery, crematory or other place or Lawn Cemi	⇔Aug.17, etery	2005 E	oc. Location - City or To Hagerstow	
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Lice		22. Name and Addre	J '	mpson I	Funeral H	ome, Inc
	Physician (Markins)	(23a. Part1. Enter the disease, or com shock, or head ailure. List only Immediate Cause (Final disease or condition resulting in death)	a	do me his 1	ig, such as cardiac o	r respiratory arres	19, MD 21	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequence	ea of):				*
	acuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Fitter the drying Cause (Disease or injury that initiated events	Due to (or as a consequence.	·				
68760,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequence	e of):				
P.O. Box 6	ne death cer the attendin hed for use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		/		23d. Date of deliver	ery Day Year
	es pe pe	by	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause giv	en in Part I.		acco use contribute to to	
of Vital Records,	e taw has b	Completed					24a. Was an autopsy perform	24b. Were auto prior to co death?	psy findings available mpletion of cause of
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Outpatient 3FI DOA Oth	26. Place of Death	(Check only one)	
on of	ding After fune	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	c. Time of 28c. Injur	4 Nursing nor	ne 5 Aresiden 28d. Describe hov	ce 6 Other (Special of the control	y)
Division	of or Attendate after death	Certification:	3 Suicide 6 Could not be determined		farm, street, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Rure State)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death occurred at the tir and/or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as s e and place, and due to	tated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1 O 1 1	29c. Licens			d. Date signed (Month,	
			30. Name and address of person who	completed cause of death /Item 22	a) (Type Print)	11667		6.15.0	75
HC	-5		Michael D	McCorneck	11110 M	edizi	Compos	Basent	un MD.
	Sta Regist		31. Date filed (Month, Day, Year) AUG 16	32. Pagistrar's Signature	Siedel				

		•	For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of r rtificate of			eg. No.	
			1. Decedent's Name (First, Middle, L	ast)			-	2. Date of Deat	h Day Year	3. Time of Death
	Physici /Medic		Albert Ross	Couchman J	r.			AU9US+	12 2005	02:25 AM
}	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	
			Washington C	ounty Hospi	tal		Hagerstow	_		on County
	Funeral Director		103-03-6828	Sex 7. Ag 1X M 2 F	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 8	9. Birtl Co 1920 Wes	nplace (State or Foreign untry) L Virginia
	D 3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	sho	5	Maryland Washi	acton	Willia					1 ☐ Yes 2X No
	28a-1	Director	10e, Street and Number	igcon	WIIII	10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath with 23s or		16505 Virginia A				21795		United S	tates
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Manial Hygiene. Is marked other then "naturel", or Items 23a or 28a-f show aumatic event, the Medical Exantract must be notified at	d by Funeral	11. Marital Status 1 □ Never Married → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1X Yes 2 1 If Yes, Give Year or Dates:	13. 10/16/43 2/6/47	Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Wh	etc.
5	72 h 'natu	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Business/	ndustry
121	vithin ne. hen.	Ig III	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retire	d)		Law Firm	
2	filled v Hygie other t		17. Father's Name (First, Middle, La	5 +	Law	yer	18 Mother's Nan	ne (First, Middle, A		
and	ntal l	Be.	Albert R. Cou						r Couchman	
7	should ind Men inarke	2	19a. Informant's Name/Relationship		19b. Mailir	na Address (Street	1		, City or Town, State, 2	in Code)
	and ealth m 27		Deidre M. Elbe		er) 65	43 Placi	d St. Fal	ls Churc	h, Virginia	a 22043
ore	Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crei				20c. Location - City or	
Ë	Pactiment:		' 4 ☐ Donation 5 ☐ Other (Spec	cify)			tory 8-1		Smithsburg	
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lic	ensee					Fiery Fund rstown Mar	eral Home yland 21742
Г			23a. Part1. Enter the dispase, or co shock, or heart failure. List on	mplications that caused	the death. Do not ent					Approximate Interval Between
, iii	Physician		Immediate Cause (Final disease or condition	-	PNEUMON	WA ATA	AMAI F	: POIL : A	2000)	Onset and Death
1	/Medical		resulting in death)		a consequence of):	0(1), 11(1	· pp / C	IBNICCA	1100	
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	rificate be executed og physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		C OBSTR	UCTIVE	MUMDAIN	ARY DIS	CASE	
30,	e exe sian a urial-		resulting in death) Last	,	a consequence of):					
68760,	cate b	edical	1	d. SMOKI	~4					
		-	IF FEMALE:	23c. If yes, outcome	of pregnancy				004 Pate of date	
Вох	eath cert attendin for use	Physiclan/A	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	Day Year
o.	at the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		_ caron (speciny) _				
Ω.	th be de		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
of Vital Records,	puires n sign	d by						1 □ Ye	es 2 No 3 Pro	obably 4 Unknown
00	w require been sig should b	Completed						24a. Was a		topsy findings available
Re	The lav	шс						autops	y prior to death?	ompletion of cause of
tal		Ö	25. Was case referred to medical				26 Place of Dea	th (Check only one	2 ☑ No 1 Ll Yes	2 No
5	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatier	nt 3□ DQA Ott	205		ence 6 Other (Spec	eifu)
of	g Phy ar this aral o		27. Manner of Death	28a. Date of Inju (Month, Da					w injury occurred	
ion	nding th. :: After e funer	atlo	1		y Year) Injury		rk?]Yes 2. □No			
Division	il or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not determine		ury · At home, farm, str c. (Specify)	reet, factory, office	9.	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	pita urs sral		29a. Certifier 1 Certifying (Check only 2 Medical Ex	hysician: To the best	of my knowledge, deat	h occurred at the ti	me, date and place	, and due to the ca	ause(s) and manner as	stated.
	To the Hosi within 24 ho To the Func completely f	edical	one)	aminer: On the basis of and manner sta	ated.	vestigation, in my o	opinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
	To t To t Com	Ž	29b. Signature and title of certifier	1/1. 00.1		29c. Licens			9d. Date signed (Month	n, Day, Year)
			Madrain K	-		`	2562		08-12-0	5
1.1			30. Name and address of person wh							
41-	2+1		WASHINGTON COL	WTY HUPIT	AL, NAGER	estoun	MARYU	4ND 21	740	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) AUG 1 5	2005 32. Hegistr	ai s oignature	1				
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For State Registrar	State of M		artment of Heal		lental Hygie		27833
Decedent's Name (First, Mid	dle, Last)				2. Date of Death		3. Time of Death
Jane Jeanette	e Cromer				Avaust	Day Ye	987 10:52 AM
4a. Facility Name (If not institut	ion, give street and number)		4b. City, Town, or Loca	ation of Death	1109051	4c. County of 0	
Washington Co	ounty Hospita	1	Hagerstown	n		Washin	ngton
5. Social Security Number 214-09-0095	6. Sex 7. Ag	e (In yrs. last birthday) 90 Yrs.		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Ye 11/21/191	ar)	Birthplace (State or Foreign Country)
Usual Residence of Decedent 10a. State 10b. Coun	hy	10c. City, Town or L					
							10d. Inside City Limits
	ington	Hagersto	1				1 Yes 2 □ No
10e. Street and Number 1158 Luther	Orive		10f. Zip Code 21740		10g.	Citizen of Wha	t Country?
11. Marital Status 1X Never Married 2 ☐ Mi	12. Was Decedent Armed Forces? arried 1 □ Yes 2 🔀	Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc.
3 Widowed 4 Divorce	If Yes, Give		1 ☐ Yes 2X No Sp	ecify:		Specify:	White
(Specify only high	ent's Education est grade completed)	16a. Dece	dent's Usual Occupation a kind of work done during DO NOT use retired)	most of worki	ing 16b	. Kind of Busin	ess/Industry
Elementary/Secondary (0-12 12	College (1-4or)+) 	ecretary			ederal	Government
17. Father's Name (First, Middl	e, Last)			Mother's Name	(First, Middle, Maid		001021210110
Victor Mille:					atherine	_	
19a. Informant's Name/Relatio		10h Maili	ng Address (Street and N	lumbor or Que	I Pouto Number Cit	hy os Tourn Cto	to Zio Codol
Lynn F. Meye			. Washington			-	
20a. Method of Disposition	LB/TCLB RCP						y or Town, State
_ '	n 3 □Removal from State (Specify)	Rest Hav	osition (Name of matory or other place) en Cemetery	08/15	/2005 Ha	gerstow	m, MD
21. Signature of Euneral Service	e Licensee	/	2. Name and Address of I				
23a. Part 1. Enter the disease,	or complications that caused	the death. Do not en	ter the mode of dying, suc	ch as cardiac o	or respiratory arrest,		Approximate
Immediate Cause (Final disease or condition resulting in death)	st only one cause on each li	MICar	YLEPHIN	WPA.	THY		Interval Between Onset and Death
,	Due to (or as	a consequence of):		21.	2		
Sequentially list conditions,	b. Pun to (or or	a consequence of):	MM FI	MU	the same		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d Due to (or as		0000	- 1 - 1	imi		L
that initiated events resulting in death) Last	C. Dua to (or as		BPILLA	HOI	ا ا ا ا حر	achi	Jeanar
,	d. Due to (or as	a consequence of):	mm/ M	Jaln	umh	m	<u> </u>
IF FEMALE: 23b. Was decedent pragnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
Part II. Other significant condi	tions contributing to death b	ut not resulting in the u	inderlying cause given in I	Part I.	23e. Did tobacc	o use contribut	te to the cause of death?
DIABETES,	NYPERTER	TETOM,	DEMENT	A,	1 ☐ Yes	22 No 3	Probabły 4 Unknown
ANYMIA	9				24a. Was an autopsy performed	prior	autopsy findings available to completion of cause of h?
25. Was case referred to medic	al		26	Place of Death	(Check only one)	10 1	TOO ELINU
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatier	Other		ne 5 Residence	6 □Other (5	Specify)

Paysician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Modical Example in continuation continuation.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Natural 2 Accident

3 🗌 Suicide

29a. Certifier (Check only one)

4 - Homicide

29b. Signature and title of certifier

Medical Certification; To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

IF FEN

23b. W Part II. 25. Wa exa 27. Manner of Death

To the Hospital or Attending Physician: The law requires that the death certificate be executed 8

State Registrar

DHMH 17 Rev 1/2001

AUG 15 2005

5 Pending

investigation 6 Could not be determined



28a. Date of Injury (Month, Day Year)

368 Mill Street Hagerstown, Maryland

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

Injury

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

62327

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

CARLOS A CROSSON Amend item/18, perFH C847, 9/23/05 III

UNK 05-5372
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print Indelible Ink. Ensure All 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year August 9, Carlos A. Crosson 2005 1:49 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington 700 Cady Drive Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ★M 2 ☐ F 578-92-4453 Yrs. 33 Director January20,1972 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Examiner must be notified at DC Washington 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 446 Kenyon Street NW 20010 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced "natural", **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Driver **Private** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Lois Louise Hines Pages 1 and 2 should be Robert Crosson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Lisa Crosson/ Wife 514 Ingraham Street NE Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln CemeteryAug. 16, 2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) GUNSHOT WOUND TORSO /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executs) Due to (or as a consequence of): Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ding IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signated 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specifyat Scene 2 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1:47 28d. Describe how injury occurred Certification: 1 Natural 5 Pending SUBTECT WAS SHOT 219/05 1 ☐ Yes 2 ⊠No death. investigation 12:00 A Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide hours after STREET TOO CADY DR, FORT WASHINGTON, MD the Hospital vithin 24 hours of 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Larry Lee Colmer Physician 130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** red umber 14171GZOY HEART If Under 1 Year If Under 24 Hrs. 9. Birthplace 8. Date of Birth (Month, Day, Year) 5. Social Security Number (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1. M 2□F Days Hours 213-74-6865 46 Yrs April 27, 1959 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show Examiner must be notified at Allegany Barton Maryland 1. Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural" or item any injury or other traumatic aven. 19198 Legislative Road 21521 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: White Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Truck 10 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Buckalew 17. Father's Name (First, Middle, Last) Be Harry Colmer Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Colmer Sr. - Brother 19198 Legislative Road, Barton, Maryland, 21521 20b. Place of Disposition (Name of cemetery, crematory or other place) Date August 17, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cumberland, Maryland 2005 Cumberland Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, MD. 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with Ketastasis Priysician /Medical Due to (or as a consequente Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r as a con Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? λq Division of Vital Records, pe 2 No 3 Probably 4 □Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Tyes 200 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 1 📉 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 2 No after death. 1 Tyes investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier 7526

State Registrar

31. Date filed (Month, Day, Year)

DR. John Mehanna

32. Registrar's Signature

902 SETON

AUG 1 9 2005

30. Name and address of person who completed cause of death (item 23a) (Type, Print)



DRIVE

Combenous, ND 21502

State of Maryland / Department of Health and Mental Hygiene 2005 27836 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ELLEN 8, 2005 I. СПТ.Р August 5:15 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Months 1 ☐ M 2 📆 F Michigan 95 214-68-9915 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 ♥ Yes 2 No Director Gaithersburg Md. Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 301 Russell Ave. 20877 United States or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status o filed within 72 hours after de l'Hygiene. Othar than "natural", or Item Black, White, etc. 1 Never Married 2 Married ☐Yes 2 Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If itam 27 is marked other than any injury or other traumatic event, IDAA once. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelle Rider Sidney J. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Miriam Stewart (Daughter) 72 Stacy Circle Windham, New Hampshire 03087-1649 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 12, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Lothian, Md. `4 Donation 5 Other (Specify) 2005 21. Signature of Funeral Service Licensy 22. Name and Address of Facility DeVol Funeral Home witin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 East Deer Park Dr. Gaithersburg, Md. 20877 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days pneumonia /Medical Du to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, (Diease of Figury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit that the death certificate be executed and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes No Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 202No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ★ patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 🖋 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attanding P s after death. I Diractor: After I Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide na Hospital of 24 hours af the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D59738 August 9, 2005 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville, MD 20850 9901 Medical T. Mish 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 11 2005 Registrar

			For State Registrar	of Maryland / Dep <i>Ce</i>	artment of H rtificate of I	Death	Reg. N		27837
	Dhysisi	20	1. Decedent's Name (First, Middle, Last)			1	2. Date of Death Month	y - Year -	3. Time of Death
	Physici: /Medic	al	Paul Joseph Champagne				Marist	J, 205	10108141
	Examin	er	4a. Facility Name (If not institution, give street and	number)		r Location of Death		c. County of Death rince Geo	race
			Doctors Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Lanham	If Under 24 Hrs.	B. Date of Birth		
L	Funeral Director		015-28-4414 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Months Days	Hours Min	(Month, Day, Year 06/25/193	6 Massa	olace (State or Foreign otry) Achusetts
	D >		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation				0d. Inside City Limits
	faryla stal	ō	Maryland Prince George						1X Yes 2 No
	the north	Director	10e. Street and Number	5 DOWLE	10f. Zip Code		10g. C	itizen of What Cour	ntry?
	h with	ai D	8655 Normal School Road	đ	20715		USA		
	deat	Funeral	11. Marital Status 12. Was D		Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
36	72 hours after death with the Maryland natural; or items 23a or 28a-1 show deal Examiner must be netitled at	by Fu	1 ☐ Never Married 2 ☐ Married 1 💢 Ye	s 2 No	1 ☐ Yes 2 🗓 No	Specify:		Specify: Whit	
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7	filed withi Hygiene. other than ent, Ire M	Completed	12	Champ	House			nabilitat	ion
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7	should be nd Mental marked o umatic eve	2	Louis Joseph Champagne 19a, Informant's Name/Relationship (Type, Print)		ina Address (Street	and Number or Rural		or Town, State, Zig	Code)
Ma	and 2 sho Balth and n 27 is my ser traums		Louise Ramos/ Sister	255	Self Word	cester Nor	ton, MA 0	2766	
ē,			20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place	ce) Da	ate 20c. I	ocation - City or To	own, State
E	Pages nent of h ant: If ite ury or or		1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	om State Lak Memori	ematory`or other plac emont al Garden	s 08/09	/2005 Dav	idsonvill	e, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee			ss of Facility Robe			al Home
	20129		White prints			polis Koad		D 20715	Approximate
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final	on each line. Metastation	1				Interval Between Onset and Death
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Ö	w requir	eted					24a. Was an		ppsy findings available
Record	0 - 0	Completed					autopsy performed?	prior to co death?	mpletion of cause of
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Sior	Attending or death. ector: After by the fune	catic	2 Accident investigation			Yes 2 □No	0()		10
Division	after d Direct Jin by	Certification;	determined 486. P	lace of Injury · At home, farm, s uilding, etc. <i>(Specify)</i>	street, factory, office	2	8f. Location (Street a City or Town, Sta	te)	ai Houte Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, dea	ath occurred at the ti	me, date and place, a	nd due to the cause	s) and manner as s	stated.
	ne Hos 24 h ne Fur detely	Medicai		ne basis of examination and/or inanner stated.	investigation, in my o	opinion, death occurre	d at the time, date a	nd place, and due t	o the cause(s)
	To th Withir To th	ž	29b. Signature and title of certifier	Tast. MO	29c. Licens	se number	29d. D	ate signed (Month,	Day, Year)
			Money Ale 17m	7	VO	1) 7999	5 70	100/10	
			30. Name and address of person who complete the AM TO ALL AM	TANK		t Cuite Of	2 I auga 1	MD 20707	
	C+	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	alli Street	t Suite 25	o Laurel,	rin 20707	
	Regist		AUG 1 0 2005	Frank B A	back				

State of Maryland / Department of Health and Mental Hygie Pen 15 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:15 PM 08/05/2005 Mary Jane Crisp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges 12405 Shelter Lane Bowie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/21/1934 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🗓 F 215-30-4785 71 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Yes 2 No Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12405 Shelter Lane 20715 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Geographic Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Society 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Eliff Mary McMahon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane Dormio/ Daughter 12042 Twin Cedar Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 08/09/2005 Clinton, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis koad bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Abdominal Aortic disease or condition resulting in death) Cheunysm. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown COPD, hypertension, Aprilic value Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💢 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 8/8/05 58388 CUMIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20716 VEFFEILY Bowie MD 4178 N.

Registrar

State

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

27 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

I Hygiene.

Pages 1 and 2 should be nent of Health and Mental

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Division of Vital Records, P.O. Box 68760,

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To the Hospital or Attending

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AUG 1 0 2005

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2005

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	1 - State Registrar	, , , , , , , , , ,	C	ertificate of	Death	,	Reg. No.	000	2100	9	
	Decedent's Name (First, Middle, La	ist)				2. Date of De	eath		3. Time of Death	1	
Physician	Dolore	es Alexine Cam	eron			AUGUST	12 200	Year)5	1:20pm	М	
/Medical Examiner	4a. Facility Name (If not institution, given		01.011	4b. City, Town, o	or Location of Death			nty of Death	1 + • 2 0 pm		
	CIVISTA MEDICAI	CENTER		LA PLA	TA		CHAR	LES			
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yrs.		Monthe Dave	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth		face (State or Fore	ign	
Director	216-24-5086	1□M 2⊠F	76 Yrs	i. Moriaio Bayo	Tiodio IVIII.		5, 1929	Mary.	* *		
D .	Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town o	r Location					Od. Inside City Lim	its	
short and a									1 ☐ Yes 2 🔀 İ		
on the Markith the	Maryland St. Mary' 10e. Street and Number	s Ca	allaway	10f. Zip Code			10g. Citizen o	of What Cour			
O with				20620				or writer cour	itiy :		
36 s after death with the Maryland or Itams 23a or 28e-f show and er court be notified at y Funeral Director	20438 Killdeer Lane	12. Was Decedent Ever in U	J.S. 1	13. Was Decedent of F	Hispanic Origin? (Spe	ecify Yes or N	USA 0- 14. F	Race - Americ	can fndian.		
Fun Itter	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 No		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	В	Black, White,			
O36 ours a ours a	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spe	c <i>ify:</i> Whit	e		
5-0 5-0 72 ho	15. Decedent's E	ducation ade completed)	16a. De	ecedent's Usual Occup	pation during most of worki	па	16b. Kind of	Business/In	dustry		
Maryland 21215-0036 d 2 should be filed within 72 hours att h and Maralt Hygelms, or ris marked other than "natural", or traumatic avant, It a M. Alfel Ex. oth To Be Completed by F	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	- lif	e. DO NOT use retire	nd)	•					
Col			Ca	afeteria Work	18. Mother's Name	/Eight Middle		School	S		
and libe fill the state of the savar						•		raine)			
ryla hould I d Men marke matic	Thomas Newton Ferra 19a. Informant's Name/Relationship		19h M	lailing Address (Street	Maude E1			wn State Zir	Codel		
Mar Mar In and 2 shutth and 27 is m	Ian Allan Cameron /			38 Killdeer I							
Thear tam ()	20a. Method of Disposition	20b.	Place of Di	isposition (Name of		ate	*	n - City or To	own, State		
Dages Pages at: If i	1 🖫 Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci	☐Removal from State Man	yland	crematory or other pla Veterans Cemetery	18,	gust 2005	Che1ten	ham. Ma	rv1and		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Department of Haalth and Mertal Hygiene. To the mary 1 is marked other than "natural, or Itams 23a or 28e-1 show any injury or other traumatic avant, the Mariest Exact at rount be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Lice	A		22. Name and Addre	ess of Facility			,	<i>y</i>		
m 88 8 8	Muchael	Lardiner		Mattingley-C P.O. Box 270				50			
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the dea	th. Do not	enter the mode of dyi	ng, such as cardiac o	or respiratory a	arrest,		Approximate Interval Between		
Prysician	fmmediate Cause (Final disease or condition	PNFUI	moa	Air					Onset and Death	n	
/Medical	findediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										
Examiner	Sequentially list conditions,	b									
), executed in and ial-transit Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):								
Box 68760, leath certificate be executed attending physician and I for use as the burial-transit cian/Medical Examir	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					-			
68760, tificate be exe g physician a as the burial-ledical Ex		d						- 11			
c 6876 srtificate be ing physici e as the bu		U									
Box eath cert attending for use a	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		200-1-1-1			23d.	Date of delive	ery		
cords, P.O. Bo: w requires that the death of been signed by the attency should be detached for us leted by Physician/	in the past 12 months?	1 Live birth 2 Fet		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	У			Month	Day Year		
by the lacke	9 □ Unknown	9□ Unknown									
S, F es that general be de	Part fl. Other significant conditions	0	sulting in th	ne underlying cause gr	ven in Part I.				ne cause of death?		
ord equir equir bould	COLON	KESECTION				1	Yes 2 No	3 🗆 Prot	pably 4 Minknov	.vn	
al Record The law requir cate has been s page 2 should						24a. Was	psy	prior to co	psy findings availat mpletion of cause of	ole of	
The The page						1 Yes	ormed? 2 No	death? 1 ☐ Yes	2 🗆 No		
Vital Fician: The certificate actor, page	25. Was case referred to medical examiner?	Hospital:		04	26. Place of Death						
of V Phyai this c aldire	1 Yes 2 No	1 Department 2	ER/Outpa	THEIR SON	her: 4 Nursing Ho		how injury occ		y)	_	
Division of Vital Records, P.O. Box 68760, If or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and birector: After this certificate has been signed by the attending physician and if in by the funeral director, page 2 should be detached for use as the burial-transit ertification: To Be Completed by Physician/Medical Examir	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Tim fnju	ry Wa	rk? Yes 2 No	zad. Describe	now injury occ	Salied			
Viten death ctor:	2 Accident Investigation 3 Suicide 6 Could not	De Blace of leight At h	nome, farm			28f. Location	(Street and Nu	mber or Rura	al Route Number,		
Division c tal or Attending P rs after death. el Director Anner ed in by the trneare Certification;	4 Homicide determined	building, etc. (Spec	ify)	,,,,			iwn, State)				
spits nerel y fille		hysician: To the best of my kn	owledge, d	leath occurred at the ti	ime, date and place,	and due to the	cause(s) and	manner as s	tated.		
Division of Vital Revenues to the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/d	or investigation, in my	opinion, death occurr	ed at the time	, date and plac	e, and due to	the cause(s)		
To the comp	29b. Signature and title of certifier	A		29c. Licen	se number		29d. Date sig				
· Ne	1 460	~~~/	-	D-44			Augu.	, ,	2005		
916	30. Na SHOTTING MAPPEN SON Who	PATEL MD 102	TAUL TX	TELLON COU	RT WALDORF	MARYI	AND 206	502			
	31. Date filed (Month, Day, Year)	32. Regist									
State Registrar	AUG 1	5 2005	1	1 South							

;	Within 2 To the complet	Medical	29b. Signature and title of certifier 30. Name and address of personatho co	and manner stated.	3a) (Type	29c. License D356			29d. Date signed (
DIVISION	lo the Hospitel of Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ical Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Examin	28e. Place of Injury - At home building, etc. (Specify) ician: To the best of my knowle er: On the basis of examination	edge, death	occurred at the tim	ne, date and place pinion, death occu	City or Tow	cause(s) and manr	er as sta	ted.
5	this ral dii	To B	evaminer?		VOutpatien Bb. Time of Injury	Worl	^{9r:} 4□ Nursing H	ome 5 ☐ Resid	dence 6 Other	(Specify)	
	10	e Completed	25. Was case referred to medical				26. Place of Dea	1 Tes	priormed? dea 2 No 1	or to com th?	sy findings available pletion of cause of
records, r	w requires man been signed to should be deta	by	Part II. Other significant conditions con	ributing to death but not resulti	ng in the ur	nderlying cause give	en in Part I.	1 🗆 \		N Proba	bly 4 □Unknown
O. DOX 00	y the ached	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnanc; 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month		y Day Year
68760,	ean benuities be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causo (Jesues of Figer) that initiated events resulting in death) Last	Due to (or as a consequer							
	nysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		rcinc	oma					Onset and Death
מ	Impo Impo any i		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.	51	. Name and Addres . 30 Wisco: er the mode of dying	nsin Ave	N.W. W	lash. D.C	. 200	
baltimore, i	perimit. Tages 1 and 2 should be proportion to the properties of Health and Menta Important: If item 27 is marked any injury or other treumatic enonge.		Elinor Conversano 20a. Method of Disposition 1 \(\) Burial 2 \(\) Cremation 3 \(\) Re 4 \(\) Donation 5 \(\) Other (Specify) 21. Signature of Funeral Service Usense	emoval from State 20b. Plac cem Arli	e of Dispo- etery, cren ngtor	Mori Dri	em. Sept	Date . 6, 05	20c. Location - Ci	ty or Tow	a.
Maryic	and Menta	2	Andrew Conversano, 19a. Informant's Name/Relationship (Type	e, Print)		g Address (Street a		ral Route Numbe			Code)
-	le the literal Hygie ked other i	Be	17. Father's Name (First, Middle, Last)		Unior	n Negotia	18. Mother's Nam	,	Foundati Maiden Surname)	on	
0000-01717	Hygiene. Hygiene. Ither than "neturel", or Ite ent, It w Medical Evanine	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give :	ent's Usual Occupa kind of work done of 20 NOT use retired	luring most of worl)	king	National	Sci	-
		by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 2 Yes 2 □ No 1946 If Yes, Give Year or Dates: 1948		Vas Decedent of Hi Yes, specify Cuba □ Yes 2 X No	Specify:	Rican, etc.)	Black,	White, et	tc.
4	s 23a or		11612 Georgetown C		10.11	20854	0.11.0/0		U.S.A.		
to the state of th	28a-f sho	Director	Maryland Montgomer		ville				10g. Citizen of Wh		1 X Yes 2 □ No
	Director		578-34-5282 Usual Residence of Decedent 10a. State 10b. County	M 2□F 76	Yrs.		Hours Min.		1,1929 D	istr	ict of Col
4	Funeral	*	Shady Grove Advent 5. Social Security Number 6. Sex	7. Age (In vrs. last	birthday)	Rockvill If Under 1 Year Months Days		8. Date of Birt	Montgo		ace (State or Foreign
	/Medic	al	Andrew Conve	ersano, Jr.		4b. City, Town, or	Location of Death		8, 2005 4c. County of	Death	3:45 A M
	Physicia	ın	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Y	ear	3. Time of Death

State of Maryland / Department of Health and Mental Hygiene 2005 27841 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 2005 Year **Physician** August 7, 9:00 AM Mary Kathleen Cooney /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Manor Care Chevy Chase Montgomery Chevy Chase If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 7,1909 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 6 Sax 7. Age (In yrs. last birthday) Funeral Months Deys Washington, DC 1 □ M 2 □XF 579-22-5830 Yrs. 95 Nov. Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours aftar death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28e-f show eny Injury or other treumatic event, the Medical Examiner must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits XT Yes 2 No Director Washington D.C. None 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20015 **IISA** 5405 31st Street, NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ②No Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: δ White Year or Dates: 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes O'Sullivan James Edward Reich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31st St., NW., Washington, DC 20015 Mary K. Cooney/Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) Aug.11 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State Gate of Heaven Cemetery 2005 4 ☐ Donetion 5 ☐ Other (Specify) Silver Spring, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 2222 Wisconsin Ave., NW., Washington, DC 20007 a. Purisher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence Examiner burial-transit To the Hospital or Attending Physicien: The law requires that tha death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as tha burial-tran Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence ot) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pega 2 s 1 TY68 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 1 ☐ Yes 2 ☑ No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To eral Director: After this filled in by the funerel di 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Menner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours aftar or To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 199 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054566 7/01 16 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) ,1220 A Eeut Dopa Road Sieth 230 TOWISN MD 21246. Suilla Bhogavini

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG

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32. Pagistrar's Signature

Mayer

State of Maryland / Department of Health and Mental Hygier 205 27842 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician August 13,2005 10:17 A Zora Rebecca Dudley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12126 Hopewell Road Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Sep T. 8, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖵 F Pennsylvania Director 77 220-22-6575 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 I marked other then "natural", or Itema 23s or 28s-f ehow ant: If item 27 I marked other then "natural", or Itema 23s or 28s-f ehow ury or other frauntsite event, the Madical Examinar must be notified a 1 ☐ Yes 2√ No Director Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12126 Hopewell Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aircraft Instrument Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Purchasing Agent Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Raymond James Duck Mayme Isabelle Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12126 Hopewell Rd. Hagerstown, Naryland 21740 to of Disposition (Name of Date 20c. Location - City or Town, State Cathy Humphrey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removar(rom State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Aug 14,2005 Smithsburg, Maryland 21. Signatur A Fyreral Service Visconse 22. Name and Address of Facility Osborne Funeral Home P.A. 425 Conococheague St. 400 6 Williamsport, Maryland 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Emphysema /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hypertension 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Peripheral Vascular Disease autopsy performed? 2√ No 1 ☐ Yes Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation injury 1 🛮 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056714 August 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saxena 11110 Medical Campus Road Suite 107 Hagerstown, Maryland 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 16 2005 Registrar

State of Maryland / Department of Health and Mental Hygian 05 271

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month 08-10-05 Year **NEANYA** 12: 00 PM **Physician** DAVIS /Medical a. Facility Name (If not institution, give street and number)
SLIGO CREEK NURSING CENTER 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY COUNTY TAKOMA PARK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 04-03-1915 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 M XX 90 MRTH CAROLINA 579-14-8340 Director Usual Residence of Decedent should be fited within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Neufcul Eyer it at marker retified at MONTGOMERY SILVER SPRING XXYes 2 No Director 10g. Citizen of What Country? 10e Street and Number 8039 EASTERN 10f. Zip Code 20910 **AVENUE** U.S.A. Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:BLACK If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
INVENTORY MANAGEMENT SPECIALIST 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNM ENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **GRAY JOHNSON** Mental 19a. Informant's Name/Relationship (Type, Pri RONALD DAVIS/ SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is meny injury or other traum 2008. 8039 EASTERN AVE. #101 SILVER SPRING, MD20910 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/12/2005 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 Denation 5 ☐ Other (Specify) Signature of Funeral Service Livensee 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME 3015 12TH STREET N.E. WASHINGTON, DC 20017 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Respirator **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/MedIcal the phys IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page performed? 1 ☐ Yes 2**X** No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Certification: Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1X Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ddress of person who completed cause of death (Item 23a) (Type, Print) YEHEYIS NEGUSSIE 12537 STRATFORD GARDEN DRIVE SILVER SPRING, MD 20904 31. Date filed (Month, Day, Year) AUG 1 2 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 05

			1 - State Registrar	Cer	tificate of	Death	Re	g. No.	
П	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Wilba Jean Drumheller				August	7 2005	0553 M
	Examin	er	4a. Facility Name (If not institution, give street and number	1		Location of Death		4c. County of Death	4
_			Doctors Hospital		Lan			Prince	Georgels
	Funeral Director		5. Social Security Number 6. Sex 7. An 2 ★ F	ge (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 30.	Year) 9. Birth Cou	place (State or Foreign intry)
	p. ,		Usual Residence of Decedent				300. 30,	1911 (1051)	engeon, bo
	arylar show	<u>_</u>	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	8a-1	Director	Maryland Prince George's	Bladensbur	g				1X Yes 2 No
	with ti	Dire	10e. Street and Number		10f. Zip Code			g. Citizen of What Cou	intry?
	eath	Funeral	5999 Emerson Street #101 11. Marital Status 12. Was Decedent	Sverie II C 12 V	20710	innania Orinina (Co.		J.S.A.	
	fter d r iten	Fun	1 Never Married 2 Married 1 Yes 2 🕅	?	f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
ဗ္ဗ	al', or	by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1	1□Yes 2X No	Specify:		Specify: Wh	ite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It we Medical Exempter must be mullified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occup	during most of worki	ng 1	6b. Kind of Business/Ir	ndustry
12	withir ane, than	фш	Elementary/Secondary (0-12) College (1-4or	5+)	DO NOT use retired	1)		- TT	
р О	filed Hygid ther		12 17. Father's Name (First, Middle, Last)	Homema	iker	18. Mother's Name		Wn Home	
Maryland	d be ental ked o	To Be	Wilbur Wesley Custer, Sr.			Jean Mar		,	
2	shoul Mand Mand	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street		-	City or Town, State, Zi	o Codel
Š	nd 2 alth a 27 is		William A. Drumheller, III						,
Je,	of Hei		20a. Method of Disposition	20b. Place of Dispos	sition (Name of natory or other place			Oc. Location - City or T	
Baltimore,	Page nent c int: if		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	'		· 1	11 2005	Alexandria	. Virginia
a	rmit. partn ports y inju		21. Signature of Furreral Service Licensee	22	. Name and Addres	ss of Facility Gas	ch's Fun	eral Home,	P.A.
<u></u>	80 5 5 8		Jalauis Francis Mc	01373	4739 Bal	timore Av	enue, Hy	attsville,	
Г			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each l	d the death. Do not ente	er the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition 5 0.6	dural H	emato	ma			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):					
		-	Sequentially list conditions, b. Due to (see	a consequence of);					
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	a consequence or):					
	эхөси n and al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
68760	eath certificate be executed attending physician and for use as the burial-transit		d						
	tificat ig phy as th	Medicai							
ŏ	th cer endir r use		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2 Fetal death 3 🗆	Ectopic pregnancy			23d. Date of deliv	ery
. B	ires that the death cer signed by the attendin d be detached for use	Physician	1 Yes 2 No 4 Pregnant a		Other (specify)			Month	Day Year
Р. О.	d by t	Phy	a □ ouknowu				TI		
က်	ires II signe	by	Part II. Other significant conditions contributing to death t	jut not resulting in the un	iderlying cause givi	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Ö	requ	etec					1 1 108	2 2 NO 3 FIO	
Records,	hysician: The law requires that the death his certificate has been signed by the atter I director, page 2 should be detached for u	Completed					24a. Was an autopsy perform	prior to co	ppsy findings available impletion of cause of
_	n: Th ficate r, pa							ZNo 1 ☐ Yes	2□ No
\equiv	sicia certi irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpati		Othe	26. Place of Death			-
ō	ding Phy h. After this funeral d	}	27. Manner of Death 28a. Date of Inju	ury 28b. Time of	1 3 □ DOA □ UIII	4 Nursing Hor		nce 6 Other (Special Control of C	
<u>o</u>	nding ath. r: Afte e fun	ation	1 □ Natural 5 □ Pending (Month, Da 2 □ Accident investigation A unit 5 □		Worl	(? Yes 2 █ No	going to	beth roo	
Division of Vital	Atte er deg ecto by th	iffica	3 Suicide 6 Could not be	jury - At home, farm, stre	eet, factory, office	2	28f. Location (Stre	et and Number or Run	al Route Number,
	tai or rs aft ai Dir ed in	Certification:	building, e	to. (Specify) Hospital	2		Lanham	State) Good Lu	d Roud
	Hospi 4 hou Funer ely fill	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of the desired property on the basis of the desired property of the desired pr	of my knowledge, death	occurred at the time	ne, date and place, a	and due to the cas	use(s) and manner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	Med	one) and manner st 29b. Signature and title of certifier	ated.	29c. License				
	F 3 F 8		1 A Qualit AO sto	7 -				d. Date signed (Month,	Day, Teal)
1			30. Name and address of person who completed cause of	Po	Print)	003077	/	Light 8	2005
14			SALVADOR SYLVETER, 3001	1505/ tal	Drives	Clever	MA	tugust 8,	
	Sta	te		rar's Signature			/	1 ma	
	Registr		AUG 1 1 2005	. K Som	W				

Downin, Francis

	/N	ysician ledical aminer
ox 68760,	h certificate be executed	ending physician and use as the burial-transit

		Please			k Indelible Ink				
		1 - For State Registrar	State of Ma	aryland / I	Department of F Certificate of		ental Hygie Reg.		27845
Physi	ician dical	Decedent's Name (First, Middle, L Francis	A.		Downin	2	2. Date of Death Month	Day 4 Year	3. Time of Death
Exan Funera Directo	niner al	4a. Facility Name (If not institution, g Buttomere Wash 5. Social Security Number 216-10-0751	ington Medic	Oal Cey e (In yrs. last bil 34	Her Glen	Hours Min.	B. Date of Birth (Month, Day, Yes	4c. County of Dea	Ath Ather State or Foreign country land
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
Maryli R-1 sho	tor		Arundel	Severn					1 □ Yes XX No
with the	Director	10e. Street and Number	1		10f. Zip Code		10g.	Citizen of What C	ountry?
death ms 23	Funeral	1210 Somerset R	12. Was Decedent I	Ever in U.S.	13. Was Decedent of H	144 Hispanic Origin? (Speci	fy Yes or No-	USA 14. Race - Am	
Iryland 21215-0036 should be filled within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or Itams 23a or 28a-1 show matic event, Its Madical Examitier must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1▼Wes 2□ N If Yes, Give Year or Dates:	√o 1944–45	-	an, Mexican, Puerto Ri Specity:	can, etc.)	Black, Wh	white
n 72 h	ojetec	15. Decedent's (Specify only highest g	Education trade completed)	16a	. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16t	. Kind of Business	s/Industry
Maryland 21215-UU36 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? Is marked other then "natural", or treumatic event, the Madical Exam	Completed	Elementary/Secondary (0-12)	College (1-4or 5		uck Driver	· · · · · · · · · · · · · · · · · · ·		Oil Compa	any
and the file of oth	Be	17. Father's Name (First, Middle, La.	st)			18. Mother's Name (den Sumame)	
ire, Maryla s 1 and 2 should I f Health and Meni ilem 27 Is marke other treumatic	J.	Amos Downin 19a. Informant's Name/Relationship	(Type, Print)	198	D. Mailing Address (Street	Hazel Ut and Number or Rural F		ty or Town, State,	Zip Code)
C = M F		Debbie Freyman	(Daughter)	8	3108 Spauldi	ng Circle,	Severn,		
		20a. Method of Disposition XXBurial 2 Cremation 3			f Disposition (Name of ry, crematory or other place	1	200	. Location - City or	
baltimo permit. Page Department o Important: If any Injury or	9	' 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		Glen	Haven Cem. 22 Name and Addre	8-8-20		Glen Burr	
n Raes	ā	178- y. C	Ju-			Funeral Ho Ly Avenue,		is, MD 21	401
Physiciai /Medica	al	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir	a consequence	epsis	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	3 Tro C	•			
f 60, ate be executed sysician and he burial-transit	cal Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence	of):				
P.O. BOX 68/R that the death certificate b ed by the attending physic detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	1		23d. Date of de Month	livery Day Year
v 8 5 8	by	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the underlying cause giv	en in Part I.	23e. Did tobacc		o the cause of death?
I HeC The law ate has b page 2 sl	Completed				-		24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
VIII	o Be	25. Was case referred to medical examiner?	Hospital:	- a = = = = = = = = = = = = = = = = = =	itrationt 30 DOA Oth	26. Place of Death (0		. 50	
ION OT nding Phys th. :: After this s funeral di	ition; T	27. Manner of Death 1 Datural 5 Pending 2 Accident investigati	28a. Date of Injur (Month, Day	y. 28b.	Time of 28c. Injury	vat 280	d. Describe how in		city)
UIVISION of or Attending s after death. I Director: After d in by the func	Certification;	3 Suicide 6 Could not determine	be as Blace of Inju	ıry - At home, fa c. <i>(Specify)</i>	arm, street, factory, office	28f	Location (Street City or Town, St		ural Route Number,
DIVISION OF To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral directorial di	edical C	29a. Certifier (Check only one) Certifying F	Physician: To the best caminer: On the basis of and manner sta	examination an	e, death occurred at the tind/or investigation, in my o	ne, date and place, and pinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
To tl withi To tl comp	W	29b. Signature and little of certifier	₹,	mb	29c. Licens	S NO 6	29d.	Date signed (Mont	h, Day, Year)
		KOFI BON	completed cause of de	301	(Type, Print) Huspi tal	Jul	(2/2m	Burn	Chu 'ri
S Regis	tate strar	31. Date filed (Month, Day, Year) AUG 1 0		r's Signature	Soule				

State of Maryland / Department of Health and Mental Hygiene 2005 27846 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Yea Richard 13, /Medical 2005 4:01 PM M August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 6. Sex 1 **X**M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 25,1908 **Funeral** Birthplace (State or Foreign Country) Months Director Yrs 213-16-2589 96 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 4 23a 27595 Three Notch Road death \ 20659 Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 Ie marked other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No þ Specify Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ဥ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Dent / Granddaughter 27595 Three Notch Road, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Depertment of H Important: If ite eny injury or ot once. 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdns. 8-19-2005 Leonardtown, Maryland Funeral S 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 P.O. Box 279 Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dehydration and **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Jemen Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy ŏ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death P.O. | ed by the e 5 Other (specify) 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Vasco Oscare 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate has birector, page 2 s autopsy performed? atora 12 1 ☐ Yes 2**%** No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3□ DOA this After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu 1 TYes 2 TNo 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 51 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24435 MERVELL DEAN RD. HOLLYWOOD AUNG 31. Date filed (Month, Day, Year) trar's Signature State Registrar AUG 1 6 2005

State of Maryland / Department of Health and Mental Hygier 1 1 5

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For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Rose Marie Etienne August 2, 2005 6:10 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Center-Hospice of Baltimore Baltimore 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 578-86-3420 Haiti Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City. Town or Location 1X Yes 2 ☐ No D.C. Washington Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 end 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or any ilury or other traumatic event, it a Medical Examinar must be once. 2001 15th Street, NW, Apt. 204 20009 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify:Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Extravil Etienne Verida Vilbrun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Alland Leandre/ Nephew 10076 Fall Rain Drive, Laurel, Maryland 20723 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 12 1

Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 2005 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or co pli-lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ple MyelomA lears Physician +0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 X No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 3□ DOA Certification: To 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident // safter dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by ŏ Hospitel within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 941 29c. License number 29b. Signature and title of certifier Thomas N. Charle St. Balto. and 21208 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) 31. Date filed (Month 32. Registrar's Signature State 2005 Registrar

tienne

State of Maryland / Department of Health and Mental Hygier 2005 27848

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar			Cei	tificate of l	Death		eg. No.	003	210	14 C
ian	1. Decedent's Name (First, Middle, Paul Injati Es	•					2. Date of Dea Month August	Day	2005 Year	3. Time of 8:15	f Death a
ičal ner	4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town, or	Location of Death		4	County of Deat	1	
	Washington Adv	entist Hos	spital		Takoma	Park		N	Montgome	erv	
			Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	nplace (State o	or Forei
	215-60-7600	1L34M 2L1F	71	Yrs.			June 15	, 19	934 Inc	dia	
1	Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	cation					10d. Inside C	itv Limi
5		gomerv								1 🗌 Yes	
Director	Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What									untry?	
		Te			20879			- J. O.,		y.	
era	7520 Cinnabar	12. Was Deced	ent Ever in U.S.	13.1	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	1	USA 4. Race - Ame	rican Indian,	
by Funerai	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc	es? ⊑ <mark>x</mark> No	1	lf Yes, specify Cuba 1 ☐ Yes 2 No		o Rican, etc.)		Black, White Specify: Asi		ian
ompieted	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kin	nd of Business/	ndustry	
npi	Elementary/Secondary (0-12)	College (1-4	lor 5+)			1)	-				
Co		4		0	ptician	18. Mother's Nam	- /Fina Middle		ealth Ca	are	
Be	17. Father's Name (First, Middle, La								ŕ		
2	Enjeti Samuel 19a Informant's Name/Relationship		achtor	401 14 77			mma Madd	_		Sin Code)	
	Vanitha Kumari		ŭ .		ng Address (Street						000
	20a. Method of Disposition				Hellingly esition <i>(Name of</i>	Place,	Montgome Date		cation - City or		1886
	1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe	cify)	ate cem	etery, crei ge Was	natory or other place hington Cem	etery	gust 11 2005	Adel	lphi, Ma		1
	21. Signature of Funeral Service Li	Scerlo			ranensado: OO Univer					J, MD 2	1090
	23a. Part. Enter the isease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. Ist only one cause on each line. Immediate Cause (Final disease or condition Pulmonary Edema Approximate Interval Between Onset and Death Onset and Death										
	resulting in death) Due to (or as a consequence of): Acute Renal Failure										
Examiner	Sequentially list conditions, if any, leading to immediate cause. This Underprise Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Metastatic Prostate Cancer Due to (or as a consequence of):										
edical E		d									
hysician/Me	250. Was decedent pregnant								3d. Date of deli Month	*	Year
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Hypertension, Sepsis									the cause of cobably 4 🔲	
ompieted							24a. Was a autop perfor	sy med?	prior to death?	topsy findings completion of c	availa ause
e C	25. Was case referred to medical					26. Place of Dea	th (Check only or		1		
0	examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No	Hospital:	patient 2 EF	VOutpatie	nt 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 Resid	ence 6	S □Other (Spec	cify)	
ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No										
Certification	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street, factory, office) City or Town, Street, factory, office									iral Route Num	nber,
edical (Physician: To the baseminer: On the baseminer and manner	sis of examination								s)
Ž	29b. Signature and title of certifier				29c. Licens			29d. Date	e signed (Mont)	h. Day, Year)	
	Markata	Q. M.			D19	971		Au	ıgust 7,	2005	
	30. Name and address of person w Kempanna Sudh				Print) rroll Ave	nue, #23	0, Takom	a Pa	ırk, MD	20912	
ate rar	31. Date filed (Month, Day, Year) AUG 10		gistrar's Signatur								

State of Maryland / Department of Health and Mental Hygien 2005 27849 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician AUGUST 2005 10:55AMM RALPH LEE ELBURN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTREVILLE QUEEN ANNE'S CORSICA HILLS NURSING CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, AUG. 9, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months MARYLAND Director 212-32-5479 67 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show 23a or 28e-f shov 1 X Yes 2 □ No **Funeral Director** STEVENSVILLE QUEEN ANNE with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21666 USA 215 COCKEY LANE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after ☐ Yes 2 X No f Yes, Give 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: r than "naturel", o Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A **FARMING** FARMER of Health and Mental Hygie if Item 27 is marked other it other traumatic avant, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ant: if Item 27 is marked o ROE ELBURN BERTHA MAE EARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 COCKEY LANE, STEVENSVILLE, MD 21666 TRINA SINCLAIR/ NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State # 5 Department of Important: If any injury or once. STEVENSVILLÉ CEMETÉRY 8-9-2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, P.A. WMW 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ung carler widely metastatic Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, any, backing to initial class. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4□Pregnant at time of death of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 2 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide pelli 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed eduse of death (Item 23a) (Type, Print) MICHAEL D. CROWLEY, M.D., 610 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, _32. Registar's Signature State Registrar

State of Maryland / Department of Health and Mental H	Hygien 2005	2
Cartificate of Dooth		

			1 - For State Registrar	State of Maryla		partment of Fertificate of		Re	g. No.		
**	Physici		Decedent's Name (First, Middle, Last, Ronald Wayne F					2. Date of Death Month August	Day Year	3. Time of Death - 11-47 AM	
	/Medio Examir		4a. Facility Name (Il not institution, give Sinai Hospita		imove	Balti	or Location of Death		4c. County of Dear Baltimo:	th	
	Funeral Director		5. Social Security Number 172-28-5313 6. Se 172-28-5313 M Usual Residence of Decedent	7. Age (In)	yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 1:	9. Bir 2, 1936	thplace (State or Foreign puntry) PA	
	Maryland a-f show	tor	10a. State 10b. County Washing		City, Town or					10d, Inside City Limits 1 ☐ Yes 2 ☑ No	
	th with the 23a or 28 In De col	ai Dire	10e. Street and Number 10591 National	Pike		10f. Zip Code 2171	1	10	Og. Citizen of What Co	ountry?	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be malified.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Kor	ean	. Was Decedent of If Yes, specify Cub		pacify Yas or No- Pican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
Fisher 21215-0036	within 72 ho iene. than "natu ine Wedical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e <i>completed)</i> College (1-4or 5+)	(Giv	edent's Usual Occup re kind of work done DO NOT use retire eman/man	during most of won	kin a	6b. Kind of Business, ouilding	Industry Contracto	
led viand	permit. Pages 1 and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medions.	To Be C	17. Father's Name (First, Middle, Last) Ronald Wayne F				18. Mother's Nam Loren	a Fille	laiden Sumame) er		
Ronald e, Maryland	and 2 sho ealth and I m 27 is me			companion	10!	591 Nati	onal Pi	ke Big 1	City or Town, State, 2 Pool, MD	21711	
$\mathcal{R}_{\mathcal{CM}_{\mathcal{O}}}$ [c ℓ	t. Pages 1 rtment of H rtant: If iter		20a. Method of Disposition 1♥ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	P	arkhea	position (Name of ematory or other plant of comet	ery 200	.20, I	oc. Location - City or Big Pool	Town, State , MD	
Bal	permit Depar Impor any ir		21. Signature of Fundal Saura, Lidens 23a, Party, Enter the disease, or complishock, or heart lailure. List only o		1	22. Name and Addre Donald E P.O.BOX	dwin The	ompson l ar Spri	Funeral I	Home, Inc	
	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Calcific	C AOV	tic st	enosis	-	st, •	Approximate Interval Between Onset and Death	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	KY Ar	tery a	isease	*		9 days	
8760,	ate be executed hysicien and the burial-transit	Ilcal Exar	that initiated events resulting in death) Last	Due to (or as a cons	sequence of);						
Division of Vital Records, P.O. Box 66	9 jii 0 s		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date ol del Month	ivery Day Year	
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tal Record an: The law requir iliticate has been s or, page 2 should			Sepsis 24a. Was an autopsy performed?						ed? death?		
Vita	ysician: Th is certificete director, pag	To Be	25. Was case referred to medical examiner?	lospital:	2 ☐ ER/Outpati	ent 3□ DOA Ott	ner .	th (Check only one) nce 6 ⊡Other (Spe	Crift/	
ion of	ttsnding Physical death. stor: After this the funeral di	ation: T	27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation	28a. Date ol Injury (Month, Day Year		of 28c. Inju		28d. Describe how		3197	
Divis	声	Certification:	3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, farm, street, factory, office 28l. Location building, etc. (Specify)				City or Town,	n (Street and Number or Rural Route Number, Town, State)			
	the Hospital hin 24 hours a the Funeral I upletely filled	ledical	29a. Certifier 1 ♣ Certifying Phy (Check only 2 ▶ Medical Exemi	sicien: To the best ol my ner: On the basis of exam and manner stated.	knowledge, dea nination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the within To the comp	W	29b. Signature and title of certifier. 29b. Signature and title of certifier. 30. Name an address of persons of control of the control of t	iena		29c. Licens	se number 24726	29 A	d. Date signed (Month	h, Day, Year)	
5H	1-5+1 Sta	ate	30. Name and a dre of perso 10 oco Alejandro Segue 31. Date filed (Month, Day, Year)	ompleted cause of death (CIVA 240 32. Registrar's Si	Item 23a) (Typi I West ignature	Belvede	ere Aven	ue Balti	more, Mary	land. 21215	
DH	Registi	rar	AUG 16 20	105 Deserve	1. p	perke					

State of Maryland / Department of Health and Mental Hygie**z**e 005 27851 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year **EMMA** Fountain 2005 August 6, 2:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Hours 1 □ M 2 1 1 F 79 Yrs. Director 579-24-6538 28, 1925 Bailey Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural; or Items 23a or 28a-f show ury or other theumstic event, Its Modical Examinar maste notified at ury or other treumetic event, Its Modical Examinar must be notified at 10b County 10d. Inside City Limits Director 1★ Yes 2 No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8809 Aquone Place 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ρ Specify: Specify: Black 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Red Cross Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Major Austin Cora (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Harris / Daughter 8809 Aquone Place Clinton MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State rematory or other pro-Vetrans Mary Land 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 8-12-05 * 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Cemetery number of Funeral Service Licensee 22. Name and Address of FacilityPope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Vascular Disease certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed/ 2 🗆 No 1 ☐ Yes 2 🗷 No 1 TYes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specily) 1 ☐ Yes 2 ☐ No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) 610 Name and address of person who compléted cause of death (Item 23a) (Type, Print) UVING avonne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2 115 27852 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2005 **Physician** Hilda Virginia Friend 7:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Nursing Moran Manor Allegany Home Westernport 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 215-14-6448 1 □ M 2 X 83 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exeminer must be notilised at MD. Allegany Westernport 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21414 Creekside Drive 21562 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes XX No Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filad within 72 h and Mentaf Hygiene. 7 is markad other than "n Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John B. Eva E. Tanner McKenzie ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Ellis Friend/ husband 21414 Creekside Drive, Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Cumberland Crematory Cumberland, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sprice Licensee 22. Name and Address of Facility Boal Funeral Home aus 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mult, cerebral Infant Immediate Cause (Final **Physician** disease or condition resulting in death) 3 Welles /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ Lear J 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed gulopat 1 Yes 1 ☐ Yes 2 ☐ No 2 PNO or Attending Physician: diractor Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Aftar th 27. Manna of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28d. Describe how injury occurred 1 Ghatural 5 Pending within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August. 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG M.D 4 BECAD Way 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registra

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Items 23 State of Maryland / Department of Health care Menyley Hosistan () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EHRER OVER 215 4b. City Town, or Location of Death 4c. County of Death SALISBURY WICMICO KOSP 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

Funeral Director

Physician

/Medical

Examiner

Director

Funeral

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Completed

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28a-f show

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Mactical Examinar must be restlied at filed within 7 Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If Item 27 is marked any Injury or a second and Injury or a second any Injury or a second any Injury or a second any Injury or a second any Injury or a second any Injury or a second any Injury or a second any Injury or a second and Injur

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

burial-transit or Attending Physician: The law requires that the death certificate be executed and Vital Records, P.O. Box 68760. the ģ has Division o

Examiner Physician/Medical \$ Completed Be ဥ Certification: To the Hospital or Attending P within 24 hours after death. To tha Funeral Director; After t Medical 4a: Facility Name (If not institution, give street and number) If Under 1 Year Months Days 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 M 2□ F Months 88 Yrs. 10/25/1916 212-01-1498 Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 S. Schumaker Dr., Apt. 10 21804 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 212 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government. Land Management 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Fehrer Mary E. Winter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Melissa Fehrer/daughter 1103 S. Schumaker Dr., Apt. 10, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/05 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service License 501 Snow Hill Rd., Salisbury, MD 21804 Could MQ, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Subdural hematoma complicating Parkinson disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) EVAMINER Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 24a. Was an autopsy performed?

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

1X Yes 2 □ No

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

Subject fell

28f. Location (Street and Number or Rural Route Number, City or Town, State) Salisbury, MD 1103 S.Schumaker Dr., Apt.10 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes

27. Manner of Death

Stratural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

D4テノチ3

1 ☐ Yes 2 TrNo

28c. Injury at Work?

29d. Date signed (Month, Day, Year) AUGUST 10, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) norkes, m.D

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury

12/26/2002

at home

28b. Time of

12:30p

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BOX 2018, SAUS, MO21802

State Registrar 31. Date filed (Month, AUG 12 Glow & Sparke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyginal 1 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Thomas A. Flowers 0700 M 704 2005 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16 Bellevue Avenue Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Yrs 82 Feb. 9, 1923 Director 213**-**12**-**5125 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ansit: if item 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or other traumatic event, "I'm Medical Energial marker ordinals at ury or other traumatic event, "I'm Medical Energial marker ordinals at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Cambridge Dorchester 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 21613 16 Bellevue Avenue 12. Was Decedent Ever in U.S.
Armed Forces?

1 ∰Yes 2 □ No
If Yes, Give
Year or Dates: WW II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas H. Flowers Edna Hall ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jane Flowers/Daughter 16 Bellevue Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' Depart nent of H Important: if ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 1 4 □ Donation 5 □ Other (Specify) **MDVeteransCemetery** 8/9/2005 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P. 308 High St., Cambridge, MD 2161.

23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardine Azzhi **Physician** mn disease or condition resulting in death) /Medical Congestine Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ZNo this 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Stural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М I Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide within 24 hours aff To the Funeral Di completely filled in To the Hospitai Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of pertifier 126388 Aug 6, 2005 Ave Hurlock mel 2/643

State Registrar

Michre

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

302 Collins

and address of person who completed cause of death (Item 23a) (Type, Print)

2005 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 27855 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14, 2005 August 11:11 a.m. Charlotte Reed /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 23140 Cobblestone Ln., California St. Mary's If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours 92 Yrs. 12, 1913 Washington, D.C. Director 578-07-9271 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural" ~ " any njury or other freumatic event." 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo St. Mary's Maryland California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20619 23140 Cobblestone Lane #311 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes aX No Specify: White Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Reed Laura VanWyck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 23395 Esperanza Circle, Lexington Park, MD 20653 Paul Reed Fletcher / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr 8-17-2005 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. uneral Servi nsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Approximate Interval Between enter the mode of dying, such as cordiac or respiratory arrest, Onset and Dealt Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or, Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to f Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 € No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 PNo P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainner stategi. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 2Ms 30. Name and address of person who completed use of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Patrick Jarboe,

31. Date filed (Month, Day, Year)

M.

22. Registrar's Signature

24035 Three NOtch Road, Hollywood, Maryland 20636

State of Maryland / Department of Health and Mental Hygiene 2005 27856 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** August 9, 5:35 P.M Goebe 1 Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurelwood Nursing Center E1kton Cecil. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 18) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1929 1⊠M 2□F 76 Baltimore, 213-26-6530 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Rosedale Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8439 Coco Road 21237 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 □ Never Married 2 □ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: þ 3 X Widowed 4 ☐ Divorced is marked other than "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be 1 Mental John Frederick Goebel Ellen Amelia Anderson .. Pages 1 and 2 should be treent of Health and Menta tent: If Item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christy Michaud 34 Mowbray Lane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Date 20c. Location - City or Town, Stete 20a. Method of Disposition August 12, Glen Burnie, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. ^¹ 4 □ Donation 5 □ Other (Specify) 2005 Park Funeral ervica Licenses 21. Signatus 22. Name and Address of Facility 127 South Main Street Crouch Funeral Home North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician dia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes 2 No certificate To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medicai Certification; Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatule and title of certifue D005 m address of person who completed cause of death (Item 23a) (Type, Print) 118 Northstreet MD gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 27857 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Arbutus L. Gillis 8, 2005 3:28 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 1 F Vrs Director 578-44-9208 87 12/27/1917 West Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercities must be notified at 1 X Yes 2 □ No MD Oxon Hill Director Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with 20745 U.S.A. 7233 Roanne Drive Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental and Mental Nellie Fuqua William Washington 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 s ment of Health an 7233 Roanne Drive, Oxon Hill, Maryland 20745 item 27 Vashti Hall, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 08/11/2005 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road, Brentwood, MD 20722 23a. P. T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physicien by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed CANDOVACCULAR OSTATA Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Kinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month. Day, Year 29c. License number 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) OUD LINE CONTER WALDERF, Md-20602 15007 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State AUG 1 2 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

		1 - For AMEND#23a Per 1 State Registrar AACO HEALTH	DEPT. 8/16/05 0		Department of F Certificate of	lealth and M Death		20 0 5 1. No.	27858
Physicia	an	Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	Day Year	3. Time of Death
/Medic		Patricia Raye Ga					08/07/20	05	12:14 PN
Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death		4c. County of Dea	ath
		2708 Felter Lane			Bowie	I If Hadas 24 Hes		Prince G	
Funeral Director		5. Social Security Number 6 263-64-8235	Sex 7. Age (I	In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 07/29/19	(ear) 9. Bi	rthplace (State or Foreig country)
		Usuat Residence of Decedent		04			0//29/19	41 V11	ginia
show		10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits
and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show raumatic event. Its Medical Examinar must be multified at	cţo	Maryland Prince	Georges I	Bowie					1 X Yes 2 □ No
or 20	Directo	10e, Street and Number			10f. Zip Code		10g	. Citizen of What C	country?
8 238 3461	rai	2708 Felter Lane			20715			SA	
ltam Dist. D	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
r, or	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	I ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	a* ab
atura cal E		15. Decedent's		16a.	Decedent's Usual Occup	pation	16	WII 3b. Kind of Business	ite s/Industry
Medi	pie	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)		(Give kind of work done life. DO NOT use retire	during most of worki. d)			rges County
giene er tha	Completed	Comonary (5 12)	2	Te	acher		S	chools	
al Hy d oth	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Ma	aiden Surname)	
Ment arke	2	Roy G. Harrell				Winifred	Batts		
is m		19a. Informant's Name/Relationship	(Type, Print)		Mailing Address (Street				Zip Code)
fealth m 27 her t		Rene J. Garcia			08 Felter L				
or of		20a. Method of Disposition 1	l l	cemeter	Disposition (Name of y, crematory or other place Lemorial		Date 20	c. Location - City o	r Town, State
rtmer		' 4 □Donation 5 □ Other (Spe		Park C	emetery			t. Peters	
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-1 shov any injury or other traumatic event. Its Medical Examinar must be notified at once.		21. Signature of Funeral Service Lic	ensee		22. Name and Addre				
		23a. Part1. Enter the disease, or co	molications that caused th	e death. Do n		apolis Ro			5 Approximate
nysician Medical xaminer	iner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentiatly list conditions, if any, leading to immediate cause Enter the John Cause (Disease or injury	Due to (or as a control of the contr	consequence of	thy				Interval Between Onset and Death
ing physician and e as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	c. Due to (or as a c		of):				
been signed by the attending pl should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc; 5 ☐ Other (specify)	y		23d. Date of de Month	elivery Day Year
ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying cause gru	ren in Part I.	23e. Did toba	cco use contribute	to the cause of death?
en si		Emphyson	- a				1 🗋 Yes	2×No 3□F	Probably 4 Unknown
as be 2 sh	ompieted	Cardions	opathy				24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
ete hi	E	/)				performe		·
artific ctor,	BeC	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	X-1	
his ce Il dire	5	1 ☐ Yes 2 No	Hospital: 1 Inpatient		tpatient 3 DOA Ott	ner: 4 ☐ Nursing Hor	me Residen	ce 6 Other (Sp	ecify)
within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t	Certification:	27. Manger of Teath Value Standard St							
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai Ceri	29a. Certifier 12 Certifying	Physician: To the best of raminer: On the basis of earning states	my knowledge	, death occurred at the tild/or investigation, in my o	me, date and place, a	and due to the cau	se(s) and manner a	as stated.
withis To th comp	Me	29b. Signature and title of certifier		MD	29c. Licens	se number	7 290	1. Date signed (Mon	nth, Day, Year)
	ate	30. Name and address of pers 31. Date filed (Month, Day, Year)		th (Item 23a) (S Signature	Type, Print)	tuenve	Annapa	Sir Mo	2 (40)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Amended #11, nls, 08/15/05, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 1 1 5

2	7	8	5	9

6:40

1_	For State
1-	Registrar

3. Time of Death

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

yrs.

Day

2 □ No

1 ☐ Yes 2 No

Physician /Medical Examiner

Funeral Director

filed within 72 hours after death with the Maryland in than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at al Hygiene. traumatic event. . Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked otl

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

other

burial-transit attending physician and use as the ō detached 2 should be d page 2 certificate director. this After thi within 24 hours efter death.

To the Funeral Director: A filled in by the

Certification:

Medical

State Registrar

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Attending Physician:

0

5. Social Security Number 10a State Directo Maryland 10e. Street and Number Completed by Funeral 11. Marital Status 12 Be 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Examiner that initiated events resulting in death) Last

Department of Important: If any injury or once. Physician/Medical ρ Completed Be · To

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month August Louise Bennett Gordon 13. 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 6, 1913 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2 1 F Months Min West Virginia 92 Yrs. 214-07-0523 Usual Residence of Decedent 10b. County 10c. City, Town or Location Frederick Monrovia 10f. Zip Code 10g. Citizen of What Country? 11792 Thomas Spring RD 21770 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes MNo If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard William Boor Virgie Mae (Bennett) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Arthur Gordon/Son 11792 Thomas Spring RD, Monrovia, MD 21770 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hillcrest Memorial Park 8/16/05 Cumberland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Authoral Service Licentee Kight Funeral Home 22. Name and Address of Facility 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Chronic Obstructive Pulmonary Disease, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes, Hypothyroidism, Osteoarthritis autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

25. Was case referred to medical examiner? 27. Manner of Death 1 XNatural 5 Pending 2 Accident 3 Suicide

4 - Homicide

(Check only one)

29a. Certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

35183

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d, Date signed (Month, Day, Year) ,2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

would mi 30. Name and address of person who co ted cause of death (Item 23a) (Type, Print)

Ali J. Afrookteh, MD, 300 West Ninth Street, Frederick, Maryland

31. Date filed (Month,

32. Registrar's Signature

.5

nds

State of Maryland / Department of Health and Mental Hygie e 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month S Year **Physician** Gulden Louise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AlleGan Cumber Lon If Under 1 Year If Under 24 Hrs. pacred MEART MOS oital 8. Date of Birth Month, Day, Year) Nov 5, 1954 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 217-66-9581 50 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other tren "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be exercised. 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Allegany MD Cumberland Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 White Avenue 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Sanitary Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Boore Violet V. Brobst Boore ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 White Avenue Cumberland MD 21502 Violet Boore nformant's Name/Relationship (Type, Print) mother 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Scarpelli Funeral Home, PA 8/4/2005 Cresaptown MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Nam}Scandellis Pune Home, PA 108 Virginia Avenue: Cumberland, MD 21502 a. Farth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, periods, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUROENDOGRINE /Medical Hematocrit Examiner Hemoglobulus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine inding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed CARDIOPULMONARY ARREST resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown for Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes X No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed?
1 Yes No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ို 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL AVE, SUITE 105 n RS SALEE M, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygie 2005 2786

			1 - State Registrar			$C\epsilon$	ertificat	e of L	Death			Reg. N			. ,	•
			1. Decedent's Name (First, Middle	le, Last)							2. Date of De				3. Time of	Death
	Physici			Mary T	obbio	Goddard	1				Month	D; 1 /		ear E	4:25	РМ
	/Medic		4a. Facility Name (If not institution			Goddard		Tours or	Location	of Doath	Augus		c. County of			
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			St. Mary's Ho		- 4 (1	1 11111			town	O.4 Uro			St. M			
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In)	rs. last birthday	Months		If Under Hours	Min.	8. Date of Bir (Month, Da	rth a <i>y, Year</i>) 9	9. Birthpl Coun	lace (State or try)	r Foreign
	Director		219-74-1531			39 Yrs.					February	7 25,	1966	Mary	land	
	pu >		Usual Residence of Decedent		100	O'to Town out										
	shov shov	-	10a. State 10b. County		100.	City, Town or I	.ocation							10	0d. Inside Cit	
	M a -t a	oto	Maryland St. Man	ry's		Lexingtor	Park								1 🗌 Yes	2 ∏ No
	r 28	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wh	at Coun	try?	
	38 c		19754 Three Notch	Dood				20652			İ		USA			
	ins 2	Funeral	11. Marital Status		edent Ever is	n U.S. 13		20653 de <i>n</i> t of Hi	ispanic Ori	igin? (Spe	cify Yes or No		14. Race -	America	an Indian	
_	Itar	5	1 X Never Married 2 Mar	Armed F			If Yes, spec	cify Cuba	n, Mexica	n, Puerto I	cify Yes or No Rican, etc.)			White, e		
-0020	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show is Medical Ever hat reast be restited at	by	3 Widowed 4 Divorced	If Yes G	ive		1 🗆 Yes	2🖄 No	Specify:				Specify:	White	۵	
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V	ed y ygie yart	ပိ	12			Homem	aker	-					n Home			
and	al H d oth	Be	17. Father's Name (First, Middle,	Last)				İ	18. Mothe	er's Name	(First, Middle	, Maidei	n Sumame)			
<u>a</u>	vid the standard when the standard stan	2	George Elmer Godd	lard					Ethe:	1 Gert	rude Ada	ms				
	2 should be and Mental Is marked c	ľ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mai	ling Address	(Street a	and Numbe	er or Rura.	Route Numb	er, City	or Town, St	ate, Zip	Code)	
Ž	allth a		Earl Vincent Bonds	/ Friend		P.O.	Box 33	St	Inipod	ac Ma	rvland 2	068/				
ນົ	1 a Hea tam	-	20a. Method of Disposition	, 1110110	20	b. Place of Disc	osition (Nan	ne of			ate 2		.ocation - Ci	tv or To	wn. State	
altimor	ages nt of i. if ii		1 X Burial 2 ☐ Cremation		State	cemetery, cre	matory or o	ther place	θ)	Aug	ust			,,		
	tmer tant		`4 □ Donation 5 □ Other (S	1	St	. George		3 15 0		19,	2005	Va1	ley Lee	. Mar	ryland	
o o	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked othar than." natural; or Items 23a or 28a-f show any njury or othar traumatic avent, the Medical Exercited in at mast ke natified at once.		21. Signature of Funeral Service	Lice 1300	1 -	M	22. Name an	Addres	s of Facilit	ty Fine	ral Home	D	٨			
	205 20		Michael	* Harr	line	VP	.U. Box	270,	Leona	ardtow	n, Maryl	and	20650			
			23a. Part1 Enter the disease, or shoot, or heart failure. List	r compliculons that	caused the d	eath. Do not er	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betw	
	Dhysisian		Immediate Cause (Final	1	11			1	-	1					9nset and D	
	Physician /Medical		disease or condition resulting in death)			DOIN	animy	11	VY5	/					hour	<u>. </u>
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ă	eath atte for	clai	in the past 12 months?		birth 2 ∏F na <i>n</i> t at time o		□Ectopic pr □ Other (sp					}	Month		-	ear
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Ľ	w requires that the death been signed by the atten should be detached for u		Part II. Other significant condition	Ons contributing to	feath but not	resulting in the	underhing o	auco dive	n in Part I		23a Did t	obacco	use contribu	ite to the	e cause of de	ath?
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รดากร	law ras be	Completed									24a. Was		24b. We	re autop	sy findings av	vailable
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0	n: T ficat or, pa		OS 1Man annu referend to medica								1 Yes		1	Yes 2	22 No	
5	Physician: The lar this certificate has al director, page 2	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only o					
5	Phys this al dii	P	1 Yes 2 No			ER/Outpatie		A	4 🗌 NU		ne 5 🗆 Resid			(Specify))	
=	ding F h. After funera	on	27. Manno of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mor	of Injury oth, Day Year	28b. Time (8c. Injury Work			8d. Describe I	how inju	ry occurred			
2	and eath or: /	atl	2 Accident investi	gation			М	1 🗆 \	/es 2 □	No						
<u> </u>	er de racte by t	tifi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Plac	e of Injury - A ling, etc. (Spe	it home, farm, s	treet, factory	, office		2	8f. Location (3 City or Tox			or Rural	Route Numb	er,
5	alo s aft al Di	Certification:			g, 0.0. (op.	55.197				1	J.,	,	-,			
	spit nara nara		29a. Certifier 1 Certifyir	ng Physician: To th	e best of my	k <i>n</i> owledge, dea	th occurred :	at the tim	e, date an	d place, a	nd due to the	cause(s) and mann	er as sta	ted.	
	To the Hospital or Attanding Physician: The law requires that the death ————————————————————————————————————	edical	(Check only 2 Medical one)	Examiner: On the	pasis of exam	ination and/or i	nvestigation,	in my op	i <i>n</i> ion, dea	th occurre	d at the time,	date an	d place, and	due to	the cause(s)	
	o thin o thin o thin o thin o	Me	29b. Signature and title of certifie				290	. License	number			29d. Da	ite signed (#	Month. D	av. Year)	
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	3		30. Name and address of person	^		tem 23a) (Type	Print)	. 16	__	_1	,	0.1				
	/		James Mc	Quistan		- ST	Mory	s the	Sput	المي	Levnu	dta	un,1	ND.		
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	Registr	ar	Alia	1 6 2005	P. Star	m B	1000									

Geofman, Eunice Baltimore, Maryland 21215-0036

1 - For State Registrar

Physicia	an	1. Decedent's Name (First, Middle, Last)	,				Month	eath Day	Year 3. Time of Death
/Medic		EUNICE GERTRUD	DE GOODMAN				Augu	St 10 0	2005 6010 M
Examin		4a. Facility Name (If not institution, give	street and number)	4	4b. City, Town, or	Location of Death		4c. Count	of Death
		Memorial Ho	soital at Eas	tow	EAS	TON		TAI	RAT
Funeral		5. Social Security Number 6. Sec	X 7. Age (In yrs. last I	pirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth .	9. Birthplace (State or Foreign
Director		217–18–1575	IM 20XF 87	Yrs.	Months Days	Hours Min.	AUG.	9, Year 91.7	PENNSYLVANIA
D		Usual Residence of Decedent							
arylan show		10a. State 10b. County	10c. City, To	wn or Loca	tion				10d. Inside City Limits
vith the Maryla or 28a-f shov be notified at	Director	MD QUEEN A	ANNE'C OUR	ENSTO	W				1 ☐ Yes 2X No
r 28a-f	Je C	10e. Street and Number	anni: 5 You	LINDIC	10f. Zip Code			10g. Citizen of	What Country?
3a or		100 LIVE ACREC I	OAD		214	558		USA	,
leath ns 2:	Funeral	109 WYE ACRES I	12. Was Decedent Ever in U.S.	13 Wa			ecify Ves or N		ce - American Indian,
fler of their	틸	1 Never Married 2 Married	Armed Forces?	If Y	es, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Bla	ck, White, etc.
urs after death wi ei', or items 23a e xentrer nust	by	3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:	10	Yes 2 ▼ No	Specify:		Specif	y: WHITE
ā 2 ···	eq	15. Decedent's Edu		a Deceder	nt's Usual Occupa	ation		16h Kind of B	usiness/Industry
in 72	Completed	(Specify only highest grade		(Give kir		uring most of work	ting	TOD. KING OF B	osinessindustry
with ene. ther	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	CLE	· ·			RETA	TT.
filed Hygi ther int, I	ŏ	17. Father's Name (First, Middle, Last)		0111		18. Mother's Nam	e (First Middle		
ntal ed o	Be	DOVIE B. ORNDORFI	7			LUCII		INE	116/
Jould J Me nark netic	6								
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturany injury or other treumetic event, the Medical once.		19a. Informant's Name/Relationship (Ty. SHIRLEY V. HENRY				ROAD, QU			
and lealth m 27 her t	- 1								
of H fite		20a. Method of Disposition 1 ■ Burial 2 ■ Cremation 3 ■ R	comai	of Dispositi ery, crema	ion (Name of tory or other place	9)	Date	20c. Location	City or Town, State
Pag ment ent: ury c		'4 ☐ Donation 5 ☐ Other (Specify)		AN ME	MORIAL	8-10-	-2005	DOVER,	PA
partr portr y inj	П	21. Signature of Funeral Service License	6/ /	22. 1	lame and Addres	s of Facility	• *****		
88 = 8	1	Chimas K.	Jellulin			CK_ROAD,			AL HOME, P.A.
		23a. Part1. Enter the disease, or compli	ications that caused the death. Do	not enter	the mode of dying	, such as cardiac	or respiratory a	arrest,	Approximate
D		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	. Congestive	. Ho	art Fo	rilure			Years.
Examiner			Due to (or as a consequenc	e of):					10
	_	Sequentially list conditions,	Due to (or as a consequence). Chronic PL Due to (or as a consequence)	rimo	rary D	iseus e			Years
sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):	7				
be executed sician and burial-transit	аш	Cause (Disease or injury that initiated events resulting in death) Last	o						
e ex ian a		resulting in death) cast	Due to (or as a consequence	e of):					
physic physic the br	ca		i						
E 00 K	siclan/Medical	IE COMME							
eath cer attendin for use	2	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea	م م	topic pregnancy			23d. Da	te of delivery
deat	2	in the past 12 months? 1 ☐ Yes 2 No	4☐Pregnant at time of death		ther (specify)			Mo	onth Day Year
t the by th ache	Phys	9 🗆 Unknown	9□ Unknown						
The law requires that the sate has been signed by the page 2 should be detache	by P	Part II. Other significant conditions con	ntributing to death but not resulting	in the unde	erlying cause give	n in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?
uire:	g g	Hypertensia [Diabetes, Adro	ncec	Deme	ntia	1 🗆	Yes 2 No	3 Probably 4 Donknown
w require been sign	Completed						24a. Was	0.45	
The lav	d E						auto	psy	Were autopsy findings available prior to completion of cause of death?
	ပိ						1 Tyes		1 ☐ Yes 2 ☐ No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			12:	26. Place of Deat	h (Check only	one)	
Physi this o	၉	1 ☐ Yes No	lospital: 1 Inpatient 2 ER/C	utpatient	3 DOA Othe	f: 4 Nursing Ho	me 5 🗆 Res	idence 6 🗆 Oth	er (Specity)
ding P. h. After t funera	ü	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury 28b. (Month, Day Year)	Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury occur	red
tendir leath. tor: Al	at	2 Accident investigation		. ,		es 2 No			
at or Attendin after death. I Director: Af d in by the fur	lific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	arm, street	, factory, office		28f. Location (City or To	Street and Numb	er or Rural Route Number,
al or	Certification:	- band - control of	building, atc. (apacity)				Ony Or 10	····, Ulaidj	
the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,		29a. Certifier Certifying Phys	sician: To the best of my knowled	ge, death or	courred at the time	e, date and place,	and due to the	cause(s) and ma	inner as stated.
B Hc	edical	(Check only 2 Medical Examir one)	ner: On the basis of examination a and manner stated.	nd/or inves	tigation, in my op	inion, death occur	red at the time,	date and place,	and due to the cause(s)
To the Hospital within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygie**2**e0 0 5

27862

DHMH 17 Rev 1/2001

State Registrar

Division of Vital Records, P.O. Box 68760,

SHALINA CHANDRA, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

32. Registrar's Signature

QMD.

31. Date filed (Month, Day, Year) AUG - 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063304

August 7,2005

State

Registrar

AUG 15 2005

Howlett, Connie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 205

					.,	Certific	ate of	Death	,	Reg. No.	, •	B40 F	
			1. Decedent's Name (First, Middle, Last)						2. Date of De	eth		3. Time	of Death
	Physicia		Denison D.	Harrield,	Sr.				Month August	4, 2005	Year	3:3	5pm
	/Medic Examin		4a Fecility Neme (If not institution, give s					4b. City, Town, or					5 P.II.
		•	Prince Georges C	ommunity	Hospit	al		Chever	1y	Princ	e Geo	rges	
	Funeral		Social Security Number 6. Sex		(In yrs. last b	irthday) If Un	der 1 Year	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da	h v. Year)	9. Birthp	lace (Stat	e or Foreign
	Director		433-58-0502 ^{1⊠}	M 2□F	90	Yrs.	IS Days	riours will	July 31	, 1915	Croc	kett	, Tx.
	p ,	-	Usuat Residence of Decedent		10. Ch. T.							011 11	014 11 11
	anyler	_	10a. State 10b. County Maryland Prince G			vn or Location ttsvill	Δ.				10		City Limits es 2 □ No
	98 1	읈		corges	11 y 44								35 2 110
	1 0 K	吉	10e. Street end Number				Zip Code			10g. Citizen of V		-	
,	ath v	<u>a</u>	4870 66th Ave.				20784) 'f . \/ \ \	Unite			
	ar de	Š	T. Marian Status	12. Wes Decedent Ev Armed Forces?		If Yes, s	pecify Cub	lispenic Origin? (S an, Mexican, Puer	opecity Yes or No to Rican, etc.)	Blac	e - Americ ck, White, o		
2	S at	7	1 ☐ Never Married 25€ Married 3 ☐ Widowed 4 ☐ Divorced	1⊠ Yes 2 □ No If Yes, Give Yeer or Dates:)	1□ Yes	2 ☑ No	Specify:		Specify	Bla	ıck	
ᇢ	hour turns	To Be Completed by Funeral Director	15. Decedent's Educ		166	o. Decedent's U	Isuat Occur	nation		16b. Kind of Bu	usiness/Inc	dustry	
5	1 72 mg	je j	(Specify only highest grede	completed)		(Give kind of life. DO NO	work done Tuse retire	during most of wo d)	rking	100.11		act. y	
272	thar thar	Ē	Elementery/Secondary (0-12)	College (1-4or 5+	•)	Minis	ter			Relig	ious		
0	Hyg Hyg ent.	Ö	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,				
<u>a</u>	id be antal ked o	O B	Duff Harrield					Annie	Davis				
<u>a</u>	nd M mer umet		19a. Informant's Name/Relationship (Type	oe, Print)	19	b. Mailing Addr	ess (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip	Code)	
Σ	od 2 27 la r tra		Ganatha J. Polk /	Daughter	1.	48 Haze	1hurs	t Ave. E	wing, N.	J. 086	38		
ē.	f Height from other	ľ	20a. Method of Disposition		20b. Place o	of Disposition (Name of or other pla	ce)	Date	20c. Location -	City or To	wn, State	
Ë	Peges nent of H ant: If ite ury or of	-	1 Donation 5 ☐ Other (Specify)	emoval from State	Arli	ngton N	ation	al Cem.	8/26/05	Arlingt	on, V	a.	
Baltimore, Maryland 21215-0020	= 본란급 .	1	21. Signature of Funeral Service License	ю //				ss of Facility r S. Pope					
Ö	Depa impo any is	- 1	Karth a	1				r s.rope 1boro Pi				207	4.7
		-	23a. Pert 1 Enter the disease, or complishock, or heart failure. List only on	cations that caused t	he death. Do	1			•		riu .	Approxim	nate
None C	hysician		shock, or heart failure. List only on	e cause on each line).						i	Interval B Onset an	
	/Medical		tmmediate Cause (Final	Renal	Failu	ro					2	mths	2
-	Examiner		disease or condition resulting in death) a			consequence	of):					m C I I	,
		ē			ple My						2	mths	3
	law requires mat me deam certificate be executed as been signed by the attending physician end a 2 should be detached for use es the burial-trensit	Examiner	Sequentially list conditions,	D	ue to (or as a	consequence	of):				-		
Ö,	e exe ian e urial-l	ŭ	Sequentially list conditions, if eny, leading to immediate cause. Enter Underfying Cause (Disease or injury that is listed exerts in control or								İ		
68760	ata b hysic the b	edicai	that initiated events resulting in death) Last	D	ue to (or as a	consequence	of):						
9		2											
Rox	v requires that the death cer been signed by the attendin should be detached for use	Completed by Physician/											
0	the a	Sic	Part II. Other significent conditions con	tributing to death but	not resulting	in the underlyin	g cause giv	en in Part I.	23b. Did 1	obecco use co	ntribute to	the caus	e of death?
л О	nat tr ad by detac	£	Respiratory	Failure					1 🗆	Yes 2 No	3 ☐ Prob	ably 42	Unknown
Vital Records,	signe d be	<u>5</u>							242 Was	an eutopsy	24h We	ere autons	y findings
Ö	neen Hoof:	ee	Coronary Arte	ry Diseas	e				perfo	rmed?	ava	ailable prion of mpletion of a contract of the	or to
ě	has t	ם									of c	death?	
<u> </u>	cate h	8							101	rae 2 Tytho	1[Yes 2	□ No
\ \frac{1}{2}	Fnysician; ine lav this certificate has ral director, page 2	å	25. Was case referred to medical examiner?	ospital:			Ott	205:	ath (Check only o				
5	this aldium	은	1 Yes 2 No '' 27. Manner of Deeth	14 Inpatient		utpatient 3 Time of	2011		flome 5 ☐ Resid	dence 6 □Oth		0	
ב	Te a	5	1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Day		Injury	28c. Inju Wo	rk? Yes 2 □ No	26d. Describe i	low injury occurr	90		
<u>s</u>	Attending Proysician; or death. ector: After this certific by the funeral director.	<u>S</u>	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	v . At home f			7163 2 1160	28f Location (Street and Numb	er or Bura	l Route N	umber
Division	after Direction	Certification:	4 Homicide determined	building, etc.	(Specify)	um, 31100t, 140	tory, omico		City or Tov	vn, Stete)	01 07 71010.		
_	pertal ours heral fillec		29a. Certifier Certifying Phys	ician: To the best of	mv knowleda	e. death occurr	ed at the ti	me, date end place	end due to the	ceuse(s) and ma	inner as st	ated.	
	Io the hospits of Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the t	edicai	(Check only 2 Medical Examinone)	er: On the basis of e	xamination e	nd/or investigat	ion, in my o	ppinion, death occu	irred at the time,	date and place,	and due to	the cause)(s)
	Withir To the	Ž	29b. Signature and title of certifier		Mil		29c Licens	se number	110	29d. Date signed	d (Month, (Эау, Үөөг,)
			> RA	M	672		0/0	12 73	ME	81	4	05	
, f.	15	-	30. Name and eddress of person who cor								· ·		
K	~ '		Revathy Murth				Rd.	Cheverly	, Md. 2	0785			
4	Stat	е	31. Date filed (Month, Day, Year)	32. Registrer	's Signature	resti)							

State of Maryland / Department of Health and Mental Hygien 2 1 15

27865 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Month **Physician** August 8, 2:10 P M LUCILLE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Chever1y PRINCE GEORGE'S COMMUNITY HOSPITAL Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 👿 F Vrs 577-68-9551 Director October 27,1919 Augusta, GA 85 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 No Maryland Prince George's Landover Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 1510 Ballinger Avenue 20785 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ♣No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ 3 Widowed 4 Divorced BLACK "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 3rd. Day Care Provider Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unobtainable Unobtainable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Temple Hill, Md. 20748 3528 Everest Drive Leroy Hill/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. 8/13/05 Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Frazier's Funeral Home, Inc. Walts 10101320 389 R.I. Ave., N.W. Wash., DC 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Heart Failure /Medical resulting in death) Due to (or as a consequence of): **Examiner** Uremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Respiratory Failure burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2⊠No the detached 9 Unknown 9 Unknown been signed t should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 🔼 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 2X No 1 Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2X No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 5 Pending investigation 1 X Natural 1 Yes 2 No death 2 Accident hours after deal 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Š 4 Homicide within 24 hours are To the Funeral Dir 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only onel 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DS D0060546 pleted cause of deal n (Item 23a) (Type, Print) 30. Name and address of person who 20785 Cheverly, Maryland 30001 Dospital Drive NIRMALA YADLA G 1 2 2005 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		For Stata Registrar		Cer	tificate of I	Death	Re	eg. No.			
Physicia		1. Decedent's Name (First, Middle, La					2. Date of Deat Month August	h Day 4	Year 2005	3. Time of Death 11:23 A	
/Medid Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. Cour	nty of Death		
LAMINI	CI	Washington A	dventist Hospit	·a1		Takoma Pa	rk		Mont	gomerv	
E			Sex 7. Age (In yrs. In		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Foreigntry)	
Funeral Director		579-74-0144	1□ M 2□XF 48	Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 19			sh., DC	
		Usual Residence of Decedent					000.		ng na	J. 1. 20	
ylan H		10a. State 10b. County	10c. City	r, Town or Loc	cation					10d. Inside City Limi	
Mar a-f sl	ţ	Maryland Prince	George's		Lan	dover				1∭Yes 2□N	
7.28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cou	ntry?	
38 o		6604 Asse	t Drive		İ	20785		Un	ited	States	
dear dear	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		Race - Ameri Black, White		
s 1 and 2 should be filed within 72 hours after death with the Maryland the alth and Mental Hygiene. Item 27 Is marked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Marked Examination ust be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Yes 2 No	Specify:	Thous, oto.,	Spe		lack	
72 hou	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give I	ent's Usual Occup	during most of work	ing	16b. Kind of	Business/I	ndustry	
ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. £	OO NOT use retired	1)					
filed w Hygier other th	S	12th			Secret				vernm	ent	
d oth	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle, f	Maiden Sum	ame)		
should ba nd Mental n marked c umatic ev	္	Otis McMick	ens					vieve			
and lam aum		19a. Informant's Name/Relationship				and Number or Rur				o Code)	
and ealth n 27 ner tr		Tyrone A. Harris				Drive, L			20785		
of Ho		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [1 0	lace of Dispos emetery, crem	sition (Name of natory or other plac		Date	20c. Locatio	n - City or T	own, State	
Pag nent ant: I ury o		'4 □ Donation 5 □ Other (Special		rmony l	Memorial	Park 8/1	2/2005	Lane	dover,	MD	
permit. Pagas 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Funeral Service Lice		. Name and Addre		tewart F	unera:	1 Home	2		
89 = 9		John.	Menous III			nning Rd.	 		DC 2	20019	
		23a. Part1. Fiter the disease, or con shock heart failure. List only	nplications that caused the death one cause on each line.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between	
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Examiner		Sequentially list conditions	. URINAMI	1 TRA	act IN	FECTION	J	Interval Betwee			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	nce of):							
cuter	Examiner	Cause (Disease or injury that initiated events	c. SEVERE Due to (or as a consequence) d. METASTA	. LE	MICOP	ENIA					
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ificate be executed physician and as the burial-transit	edicai		d. IVIE (ASTA	(10	BICEA	71 CX	+146516				
a G		IF FEMALE:	23c. If yes, outcome of pregna	ncv				224	Date of deliv		
death certif e attending ed for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	•			Month	Day Year	
o o	ysic	1 Yes No	9 Unknown	saui J	Cities (specify)						
w requires that the death cer been signed by the attendir should be detached for use	by Physician/M	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot	bacco use c	ontribute to	the cause of death?	
signe signe	by	HYPERT	SUSION		, ,		1 □ Y€	es 2 No	3 □ Pro	bably 4 Unknov	
requ	Completed	- 17101	C112(01				04- 146				
law as t	npl						24a. Was a autops perforr	sy .		opsy findings availab ompletion of cause of	
m ~ 0	20							2 No	1 Yes	2 No	
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	Be C		Hospital: 1 Inpatient 2	ER/Outpatien		4 U Nursing Ho	ome 5 Reside			fy)	
	To Be	1 Tes 2 No		28b. Time of	28c. Injur Wor	Kr	28d. Describe ho	ow injury occ	currea		
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	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	be 38a Bloom of laiver. At he	ome, farm, stre		763 2 110	28f. Location (St City or Town		mber or Rui	al Route Number,	
	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	be d 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		City or Towr	n, State)			
Hospital or Attending Physician: 4 hours atter death. Funeral Director: After this certification by the funeral director;	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier Certifying P	be 28e. Place of Injury - At ho	ome, farm, stre	eet, factory, office	ne, date and place,	City or Town	n, State) ause(s) and	manner as	stated.	
Hospital or Attending Physician: 4 hours atter death. Funeral Director: After this certification by the funeral director;	To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Injury - At he building, etc. (Specify thysician: To the best of my known and manner stated.	ome, farm, stre	eet, factory, office	ne, date and place, pinion, death occur	City or Town and due to the cared at the time, di	n, State) ause(s) and	manner as	stated. to the cause(s)	
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	-	For State Registrar	State of Ma	ryland /		irtment of F tificate of			gien Reg. No		27867
	_	1. Decedent's Name (First, Middle, Las	st)					2. Date of De	ath Da	y Year	3. Time of Death
Physicia /Medica		ELEANOR 1	tocker_					8	8	05	2300 M
Examine		4a. Facility Name (If not institution, give					or Location of Deat	h		. County of Dea	
		Collington Episco						1		cince Ge	
Funeral Director		038-16-2448	ex 7. Age □M 2ŽLF	87	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 19. Year 191	9. Bir 7 Ore	thplace (State or Foreign ountry)
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
Manyl	ō	Maryland Prince G	enroes	Mitch	1e11v	i11e					1X Yes 2 □ No
28a	rec	10e. Street and Number	corges			10f. Zip Code			10g. C	tizen of What C	ountry?
n with	Funeral Director	10450 Lottsford R	oad			20721			USA		
deat	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	er in U.S.	13. V	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No)-	14. Race - Am Black, Whi	
S	ò	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 N If Yes, Give Year or Dates:	lo		I□Yes 2XINo	Specify:			Specific	nite
72 ho	eted	15. Decedent's Ed	ducation de completed)	1	(Give	lent's Usual Occup kind of work done	during most of wo	rking		(ind of Business	•
ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. L	DO NOT use retire	d) _		, ,	y Specia	a 1
led w tygier her th		17. Father's Name (First, Middle, Last,	5	I	Libra	rian	18 Mother's Na	me (First, Middle		vices	
Tibe fi	Be	Carl E. Hocker					Eleanor	•		, obmano,	
hould d Me mark metlo	၉	19a. Informant's Name/Relationship (Tyne Print!	1	I9h Mailin	a Address (Street	and Number or Ri			or Town, State.	Zip Code)
IVICA Id 2 s Ith an Ith an Ith an Ith an Ith an		Margaret H. Small					Drive Al				
Heal Heal		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other pla	cal	Date	20c. L	ocation - City or	Town, State
Pages ent of ry or		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil				matory	l l	10/2005	Wale	dorf, M	
Deficiency of control of moortents of moortents of any injury or concent.		21. Signature of Funeral Service Lice									eral Home
g gg g g	j	1 Lelto	•		1	6000 Ann	apolis R	oad Bowi	e, 1	MD 2071:	5
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	irrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			ER	DEME	NTTA				Onset and Death 20 YEARS
/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):						
Examiner		Sequentially list conditions, if any, leading to immediate	b. ATHE	ROSC	LER	One H	HEART O	DISEASE	3		20 YEARS
ed sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									20 40 400
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icate be executed physician and sthe burial-transit	alE	l	d								
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ecords, P.O. box or law requires that the death certifica as been signed by the attending pl 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	1/			23d. Date of de	,
death	sicia	in the past 12 months?	4☐Pregnant at			Other (specify)	7			Month	Day Year
w requires that the de been signed by the should be detached	hys	9 🗆 Unknown						an Pid			
s, ses the igned	by	Part II. Other significant conditions	contributing to death be	ut not resultin	ng in the u	nderlying cause gi	ven in Part I.		_		o the cause of death?
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e law has by ge 2 st	Completed							24a. Was			utopsy findings available completion of cause of
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Or VICAL Physicien: The Physicien: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			— Ott		ath (Check only			
hys this	٦.	1 Yes 2 XNo	1 ☐ Inpatie		Outpatier b. Time of	IT JUDOA	4 Nursing i	Home 5 Res			ecity)
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LIVISION I or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not b	e 28e. Place of Inju		, farm, str	eet, factory, office		28f. Location	Street a	and Number or F	Rural Route Number,
al or safter or la line in the interest of the	Certification:	4 Homicide	building, etc	с. (Бресіту)				City or To	WII, Sta	10)	
To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	ledical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis of and manner sta	examination	dge, deatl and/or in	h occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(date ar	s) and manner and place, and du	s stated. e to the cause(s)
o the	¥ĕ	29b. Signature and title of certifier	Con	0_		29c. Licen:	se number		29d. D	ate signed (Mor	th, Day, Year)
F > F 0		MARY RU	DH LOPEZ	2	1	D4	6834			8/9/03	
:		30. Name and address of person who	completed cause of d	eath (Item 23	Туре,			066.10		40.0	1.020-
		7525 GREEN W				SUITE 1	13 GV	USGUBI	24	MO	20110
Sta		31. Date filed (Month, Day, Year)	32. Aregistr	ar's Signature	е						
Registr	_	AUG 1 0 2	DOD COM	e s	4						
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 15 27868 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 2005 **Physician** August 8, Ronald Edward Hart 2:00 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5848 Ross Neck Road Cambridge Dorchester 8. Date of Birth Month, Day, OCt. 9, 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^Y 193<u>7</u> 10M 2□ F Months Days Hours 67 Yrs. 063-30-6930 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28e-f show ir than "natural", or Items 23a or 28e-f ehov the Modical Examinar must be notified at 1 Yes 2 No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5848 Ross Neck Rd. 21613 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 10 Specify: Specify: ð White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any Injury or other traumatic access. Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anges Buitkus Harold Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5848 Ross Neck Rd., Cambridge, MD Judith A. Hart/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State MidShoreCremationCenter 8/9/2005 4 ☐ Donation 5 ☐ Other (Specify) Cambrid e, MD 21. Signator of uneral Service Licens 22. Name and Address of Facility
Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 21613 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer ayrs 4 months **Physician** na /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Dav Year 4 □ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by the should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 2 No Yes or Attending Physician: after death. Director: After this certification 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signal 29d. Date signed (Month, Day, Year) re and title of certities 29c. License number D3988 ress of person who completed caus of death (Item 23a) (Type, Print) Dr. David Smith, 29466 Pintail Dr., Easton, MD 21601 31 Date filed (Month Day Year) 32. Registrar's Signature 2005

State Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryland /		tment of H <i>ficate of L</i>			a. No.	27869
	Dhusiais		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Rivers Ashley Herb	ert				August	8, 2005	4:45 p M
	Examin		4a. Fecility Name (If not institution, give s		4	lb. City, Town, or	Location of Death		4c. County of D	
			1707 West 7th stre			rederic	k If Under 24 Hrs.	2 - (2:0)	Frederi	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
	Director		225-05-7436 Usual Residence of Decedent	6.5				Dec. 5,	1921 V	irginia
	land ow		10a. State 10b. County	10c. City, To	wn or Local	tion				10d. Inside City Limits
	Mary I sh	ţō	Maryland Frederic	c Frede	rick					1 ∑Yes 2 ☐ No
	r 28e	<u>e</u>	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	h witl	Funeral Director	1707 West 7th Street	et, Apt. 102		21702		Ur	nited Sta	tes
	deat	ner	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Wa	is Decedent of Hi	spanic Origin? (Spanic Origin?)	ecify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
9	or ite	교	1 Never Married 2 Married	1 ☐XYes 2 ☐ No If Yes, Give		Yes 2 XNo	Specify:	,,	Specify: W	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Medicul Exarch et mast be rediffed at	d by	3X Widowed 4 ☐ Divorced	Year or Dates:						
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72	withir ane. then	F	Elementary/Secondary (0-12)	College (1-4or 5+) Δ		ting Man			Construc	tion
20	e filed within al Hygiene. other then " vent, ITE ITE	ပ္သ	17. Father's Name (First, Middle, Last)	2 A	ccodii	cing nan	18. Mother's Name	e (First, Middle, M		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Heath and Mental Hygiene. If Item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event. If a Medical Exarther mast ke notified at	To Be	William Rivers Herl	pert			Margarite	Belcher	Herbert	
ary	shou and N s mar		19a. Informant's Name/Relationship (Type			,	and Number or Rura			
	and 2 alth a 127 is er trei		Helen Curtin / Frie				Street, ap		ederick,	MD 21702
ore	of He of He fiter		20a. Method of Disposition 1 XBurial 2 Cremation 3 Re	20b. Place ceme	of Dispositi stery, cremai	ion (Name of tory or other place	e)		20c. Location · City	
Ĭ	Page nent o ent: If ury or		'4 □Donation 5 □ Other (Specify)	Quant		Nat. Cem		/ 2003		Virginia
Baltimore,	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licens	θ /			ss of Facility Sta			
<u> </u>	20 E 2 9		Brodly JA	may o			umtown Pi			
П	_		23a. Part1. Enter the disease, or complice shock, or heart ailure List only on	eations that caused the death. De e gausses each line.	o not enter	the mode of dying	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Myoca	rdi	cal	Anga	reles	_	
	/Medical Examiner		resulting in death)	Due to br a la consequenc	ce of):		Infa ery de erases		_	GUIM
		-	Sequentially list conditions, b	Due to for as a population	ry	aru	my a	cour	- 5 60	8 700
	bed nsit	nlne	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Para		a the	irane	arree	-	15ueas
	al-tra	Examin	that initiated events cresulting in death) Last	Due to (or as a consequence	ce of):	- /				201
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687		edical							1	
Вох	death certif e attending id for use as	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	a 🗆 =				23d. Date of	delivery
	death e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		ctopic pregnancy Other <i>(specify)</i>			Month	Day Year
0	y th	Physiclan/M	9 Unknown	9□Unknown						
ď.	requires that een signed b nould be deta	by P	Part II. Other significant conditions con	tributing to death but not resulting	g in the und	erlying cause give	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ıd	w require been sig should t	eted						1 ☐ Ye	s 2 No 3	Probably 4 Unknown
SC	law re as be 2 sho	plet						24a. Was ar autopsy		autopsy findings available to completion of cause of
ž	The age	dmo						perform		1?
of Vital Records,	icien: 1 certifical rector, p	Be C	25. Was case referred to medical examiner?				26. Place of Deatl			
>	di Si	2	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient		4 Nursing no	-/\	nce 6 Other (5	Specify)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	b. Time of Injury	28c. Injun World		28d. Fescribe hor	w injury occurred	
sio	Attending r death. ector: After by the fune	catl	Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	00/ 1 11 /01		
Division	l or At after d Direct I in by	Certification;	4 Homicide determined	28e. Place of Injury · At home, building, etc. (Specify)	, farm, stree	t, factory, office		City or Town,	eet and Number of , State)	r Rural Route Number,
Ц	urs urs arel		Continue Physics	iniam. To the best of an impossion	doo daash a		an data and place	and due to the co		
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical		ician: To the best of my knowled ner: On the basis of examination and manner stated.						
	2 5 5 5	₹ Z	29b. Signature and tiple of certifier	•		29c Licenso	e number	_ 29	d. Date signed (M	
	Fo th	-	200. Orgination prior type of springs			200. 2,00010				onth, Day, Year)
)		_	MIMA	MM		Do	9518		8-9-1	onth, Day, Year)
)		V	30. Name and address of person who co	mpleted cause of death (Item 23:	a) (Type, Pr	20	9518		8-9-6	onth, Day, Year)
5	X//Y withi comp		30. Name and address of person who co Jean Poirier 186	Thomas Johnson	Drive	DO nint)	9518 102, Fred	erick, M	8-9-6 D 21702	onth, Day, Year)
5		ite	30. Name and address of person who co Jean Poirier 186		Drive	DO nint)	95/8 102, Fred	erick, M	8-9-0 D 21702	onth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 05 27870 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hutzell 5:32 PM Darah 10 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Hospital Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 M 200 Yrs. Director 216 38 1456 85 6-27-1920 PA Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director PA Bedford 1 Yes 2 No Hundman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2783 Hyndman Road 15545 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be file Depuriment of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumstic avent. ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George E. Clites Minerva Viola Mull 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry B. Hutzell, son 163 Log Cabin Road, Hyndman, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 PRemoval from State
4 Donation 5 Other (Specify) Hundman Cemetery 8-14-2005 Hundman, PA 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Harvey H. Zeigier Funeral Home, Hyndman, PA 23a, Part T. Enter the disease, of com-shock, or heart failure. List only clications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic **Physician** Cancel disease or condition resulting in death) week /Medical Due to (or as a consequence of): Examiner acidosis Metabolic Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi 4 hour ardiac desthhithmia Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 21 No certificate 1 ☐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide filled in I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Liamor MD 6 Res-000 August 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 1 ... Sheet Baltimore MD 21287-9106 n RS Marcucci Lisa 31. Date filed (Month, Day, Year) AUG 1 5 2005 State Registrar

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			1 - For State Registrar		laryland / D	epartifi C <i>ertifi</i>	nent of H cate of L	eaith and i Death	Mental Hy	gienę Reg. No.	2005	27871
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~	Examir Funeral		4a. Facility Name (If not institution, Prince George 5. Social Security Number 216-21-1520	s Hospital		day) If t	Chever	Location of Death Ly If Under 24 Hrs. Hours Min.	8. Date of Bir	rth	County of Death Prince Ge 9. Birthp Cour	eorge's
	Director		Usual Residence of Decedent 10a. State 10b. County		1 / ¹				7-16-	-1988	Mary	
	ith the Maryla or 28a-f ehor	Director	Maryland St. M. 10e. Street and Number		Le	eonar	d town				zen of What Cour	
036	a within 72 hours after death with the Maryland liene. r then "naturel", or Iteme 23a or 28a-f ehow If a Medical Examinar must be notified at	Funeral	41480 Norris St 11. Marital Status 1 Nover Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	Ever in U.S.		20650 Decedent of Hi , specify Cuba es 2½ No	spanic Origin? (S n, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)) -	nited St 14. Race - Americ Black, White, Specify: Bla	ean Indian, etc.
Maryland 21215-0036	d within giene. r then	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 11	Education grade completed) College (1-4or		Give kind life. DO N	Usual Occupa of work done d OT use retired, tudent	luring most of wor	king		nd of Business/Ind	•
yland 2	should be filed and Mental Hygician warked other umatic event,	To Be C	17. Father's Name (First, Middle, L Paul Matthew H	•	,				e Marie	Herb	ert	
, Mar	nd 2 shallith and 27 is m		19a. Informant's Name/Relationshi Paul Holt/ Fath		19b. 1	Mailing Ad 5219	dress (Street a Scott (ond Number or Ru Court, Le	ral Route Numb exingtor	er, City or n Par	r Town, State, Zip k, MD 20	Code) 0653
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.		20b. Place of Cemetery Charle:	cremator	or other place		Date 0-2005		cation - City or To nardtown	wn, State n, Maryland
Balt	permit. Depertr Imports any Inj		21. Signature of Funda Service L	censee	M01206			s of Facility Bri				
	Physician /Medical Examiner	ilner	23a. Pan 1. Enter the disease, or o shock, or heart failure. List of the classes or condition resulting in death) Sequentially list conditions, and the classes of the classes or conditions.	aDue to (or as	ine.,	I	mode of dying		or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	lificate be executed g physicien and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c	a consequence of):				-		
О. Вох	requires that the death certificate be executed een signed by the ettending physicien and rould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		pic pregnancy er (specify)			2	3d. Date of delive Month	ry Day Year
rds, P	8	Ď	Part II. Other significant condition	s contributing to death t	out not resulting in t	he underly	ing cause give	n in Part I.	23e. Did to		se contribute to th	e cause of death?
Vital Records,	The law ete hes b page 2 st	Completed									prior to con death?	osy lindings available npletion of cause of 2 No
₹	Phys this aldia	ation: To Be	25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	Hospital: 1 X Inpati	ary 28b. Tir	ne of	DOA Othe	4 ☐ Nursing He	ome 5 ☐ Resid	dence 6	Other (Specify occurred	. 1 . 1
Divis	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	al Certification:	3 ☐ Suicide 6 ☐ Could no determin 29a. Certifier 1 ☐ Certifying	ed 286. Place of in	jury - At home, farm tc. (Specify)	PE	T	e date and place	281. Location (S City or Tov	Street and State)	Number or Rural	Route Number,
	To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Expone) 29b. Signature and title of certifier	caminer: On the basis of and manner st	it examination and/	or investig	ation, in my op	inion, death occur	red at the time,	date and p	place, and due to	the cause(s)
			30. Name and address of person w					C.M.E.			st 16, 2	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 18	2005 32. Filipistr	1. rar's Signature	II Pe	nn Stre	eet, Balt	imore,	Mary.	Land 212	01

State of Maryland / Department of Health and Mental Hygien 2005 27872 1 - Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Vear Helen Marie 17. Hynson 2005 /Medical 1:20 p.m. August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24611 Blackistone Road Hollywood St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Hours 1 ☐ M 2 图 F Vrs Director 579-54-5145 65 1939 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits traumatic event, the Medical Exandrar must be notified at Director 1 ☐ Yes 2 PNo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a 24611 Blackistone Road 20636 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, Item Medical Exercit 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ဂ္ Alfred Francis Russell Carrie Adelaide Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Hynson / Husband 24611 Blackistone Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 8-22-2005 Hollywood, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Simons Kyle/ M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 2000 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No sete has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an autopsy performed 1 ☐ Yes 20 No After this certific funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one, Hospitaf: Other: 4 Nursing Home 51 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 2005 27873

			1 - Stata Registrar			,	(Certifica	ate of L	Death			Rag. No.	0.0	21010
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	Examin		4a. Facility Name (II					4b. C	ity, Town, or	Location of D	Death		4c. Co	unty of Death	
		6			s Hospita					onardto				St. Ma	ry's
100	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 6 F		yrs. last birth	Month	der 1 Year		Min. (/	ate of Birt Month, Day	r, Year)	9. Birth	place (State or Foreign
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	land		10a. State	10b. County		10c	. City, Town	or Location							10d. Inside City Limits
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	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "netural", or Items 23c or 28e-f show other treumatic event, the Madical Examinations! Le notified at		Kathrvn	McCart	thy / Dau	ghter									MD 20653
je,	s 1 a of Hez item		20a. Method of Disp	osition		20	b. Place of D	Disposition (for crematory of	lame of		Date	JCXIII		ion - City or T	
Ĕ	Page nent c nnt: If		1 2 Burial 2 L `4 □ Donation		3 □Removal from pecify)		alvary			1	-19 - 20	005	Joodsi	ide. Na	ew York
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature i Fur	neral service	Pensee										ome, P.A.
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			23a. Part1. Enter th shock, or hear	e disease, or t failure. List	complications that	caused the c	death. Do no	t enter the m	ode of dying	g, such as car	diac or resp	piratory arr	est,		Approximate Interval Between
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of V	hysia this o	၉	1 ☐ Yes 2 ☑ 1				2 ER/Outpa	atient 3 🗆 I	Othe	. 4 🗆 Nursin	g Home	5 🗆 Reside	ence 6 🗆	Other (Specia	(y)
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ζΑΤ isic	death. ctor: A y the fu	cat	2 Accident 3 Suicide	investig	not be			М		es 2 □ No					
KATHI Division	l or Atten after deat Director; I in by the	Certification:	4 Homicide	determ	ined 289, Plac	e of Injury - A ding, etc. (Sp	At home, farm <i>ecify)</i>	s, street, fact	ory, office		28f. L	ocation (St city or Town	reet and Nu n, State)	umber or Rura	al Route Number,
Clan	Hospitel	Ö	29a. Certifier	17 Cartifyin	g Physician: To th	a hast of my	knowledge	doath accurre	d at the time	o data and al			/->		
100	e Ho: e Fur letely	Medical	(Check only one)	2 Madical	Eventualer. Oll (119	basis of exam	nination and/	or investigation	on, in my opi	e, date and pi inion, death o	ccurred at	the time, d	ause(s) and ate and plac	i manner as s ce, and due to	tated. the cause(s)
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			> NU	MID	Wha			(1)00	6047	3		8/16	/ 2000	
			30. Name and addre	ss of person	who completed cau	ise of death (Item 23a) (Ty	(pe, Print)					, /		
_			MEHRDAD			MARY	S HOS	PITAL	LEONA	RDTOWN	MD.	20	650		
	Sta		31. Date filed (Monti		2005 32	Registrar's Si	gnatue	PITAL	¢°						
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State of Maryland / Department of Health and Mental Hygien 0 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Marie Honkala 2005 14, August 7:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert County Nursing Center Calvert Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2 K F Hours Director 504-18-7797 78 Oct. 10, 1926 South Dakota Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland | St. Mary's Lexington Park Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e or 19507 N. Snow Hill Manor Road Funerai U.S.A. death 12. 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Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Honkala / Son 19507 N. Snow Hill Manor Road Lexington Park MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 8-18-05 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Ligensee 100 P.O. Box 279 Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC 5 minutes Physician ARRHYTHMIA /Medical Examiner Cardio Vasiular diseave Htherosclerohic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ , Hypertensive Heart direct 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed ubliciency, Congestive Heart Fairure 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performer fibrillation, Chronic Respiratory insult 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. if Director: And in by the f 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17/05 L.C 50653 huara. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN.C. '51 -Denle Church ton Deale in Read

State

AUG 18 Registrar

egistrar's Signative

Please '	Type or Print in Black Indelible Ink. Ensu	re All Copies Are Legible.	
For	State of Maryland / Department of Health a	and Mental Hygien 2005	2787
1 - For State Registrar	Certificate of Death	Reg. No.	
Decedent's Name (First, Middle, Las	<i>t</i>)	2. Date of Death	3. Time of Dea

			State Registrar				Ce	rtificat	e of	Death			Reg. No	0.			
-	Physici		1. Decedent's Nam Wi	ne (First, Middle, L lfredo		Hernan	dez					2. Date of De Month	eath Da	-	rear	3. Time of [Death
1	/Medic	_	4a. Facility Name ((If not institution a	ive street and no	mherl		4b City	Town o	r Location	of Death	August		2005 County of	Death	3:25 1	P
	Examir	ier	Howard C							Location	OI DOGUI				Douth		
	Funeral		5. Social Security !		Sex	7. Age (In yrs	. last birthday)	Jess If Under	r I Year	If Under	24 Hrs.	8. Date of Bir	rth	oward	9. Birthr	lace (State or	Foreign
	Director		none Usual Residence of	of Danadast	1 ⊠ M 2□F	31	Yrs.	Months	Days	Hours	Min.	Oct.	6,1	973	HC	ndura	.S
	72 hours after death with the Maryland neture!; or Items 23a or 28a-1 ehow Items 12a is suffilled at	or	10a. State Md	10b. County Howard	đ		ity, Town or Lo								1	0d. Inside City	
	or 28a-	by Funeral Director	10e. Street and Nu					10f. Zip					10g. C	itizen of Wh		•	
	238 181	ia i	8834 '.	Tama Dr	ıve				210					Hono	lura	ıs	
	ltems	une	11. Marital Status	ried 2 ∑ Marned	Armed F	edent Ever in U orces? 2X No						ecify Yes or No Rican, etc.)	0-		Amend White,	an Indian, etc.	
036	ol', or	by F		4 ☐ Divorced	If Yes, G Year or I	ive		1 🚰 Yes	2□ No	Specify:	Hone	duras		Specify:	V	hite	
5-0	72 ho	eted	(Spe	15. Decedent's scify only highest g	Education rade completed,		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occup	ation during mos	st of worki	ng	16b. i	Kind of Busi	iness/In	dustry	
21215-0036	within lene. then	Completed	Elementary/Sec	ondary (0-12)	College (1-4or 5+)		ndsca					Lar	ndsca	ре	Co.	
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "neturel", or Items 23a or 28a-1 ehow eny injury or other traumatic event, it a Murical Exam and must be appresed.	To Be C	17. Father's Name	(First, Middle, Las	*							(First, Middle		,		andez	
ary	shoul and Me mari	<u>-</u>	19a. Informant's N	Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street	and Numb	er or Rura	I Route Numb	er, City	or Town, S	tate, Zip	Code)	
	and 2 ealth im 27 i			Campo:	s/Frier					ed La	_	#301 C			•		5
Baltimore,	Pages 1 nent of H int: If Ite			Cremation 3		01-1-	Place of Dispo cemetery, cre-	matory or o	ther plac	ce)		ate 10/200		ocation - C	•		
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9			23a. Part1. Enter shock, or he	the disease, or co an failure. List on	mplications that y one cause on	caused the dea	th. Do not en	ter the mod	de of dyin	ng, such as	cardiac o	r respiratory a	ırrest,			Approximate Interval Betw	een
	Physician /Medical Examiner		Immediate Cause disease or conditi resulting in death)	(Final on	a. H	4 /// (or as a conse	7/1	16,	7							Onset and De	eath
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Вох	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? ☐ No	1 Live	tcome of pregn birth 2 Fet nant at time of nown	al death 3[⊒Ectopic pr ⊒ Other (sp		′				23d. Date Monti			ear .
, P.O.	that the		Part II. Other sign		contributing to	leath but not re	sulting in the u	inderlying c	ause giv	en in Part I		23e. Did	tobacco	use contrib	ute to th	e cause of de	ath?
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ion	nding ath. r: Afte e fune	ation	1 Natural 2 Accident	5 Pending investigati	TO (1) MOI	8/1/05	Iniury	SPM	28c. Injur Wor 1 🔲	k? Yes 2) ⊋				harg		Self	
Division	or Atterderies de irecto	Certification:	3 Suicide 4 Homicide	6 Could not determine		e of Injury - At I	nome, farm, st. ify)	reet, factory			2	28f. Location (City or To	Street a	nd Number	or Rura	Route Numb	8 Rd
0	pitel o	Cer	00- 0 -7	.50		D	etoution				- 3	Jessup	M.	D 20	79.	4	
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	29a. Certifier (Check only one)	1 Certifying F	aminer: On the t	e best of my kn casis of examin iner stated.	owledge, deat ation and/or in	h occurred ivestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date an	s) and manr id place, an	ner as st d due to	ated. the cause(s)	
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1.00	Sta Regist		31. Date filed (Mo.		005	Registrar's Sign	ature	well .									

State of Maryland / Department of Health and Mental Hygie 2005 27876

			1 - Stata Registrar	, , ,	Cert	ificate of	Death	Red	. No.	21010
ı	Physici		1. Decedent's Name (First, Middle, Last,	Hende				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	T	4b. City, Town, or	Location of Deatl		4c. County of Death	
			Mariner Nursing H	lome		Laure1			Prince Ge	roes
	Funeral Director		5. Social Security Number 6. Se 004-07-0512 Usual Residence of Decedent	x 7. Age (In yrs. la QM 2□F 89	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 03/04/19	9. Birth Con	place (State or Foreign intry)
	anyland show	_	10a. State 10b. County	10c. City,	, Town or Loca	ation				10d. Inside City Limits
	8a-f	Director	Maryland PrinceGeo	orges Laur	rel	1				1X☐Yes 2☐No
	death with the Maryland ms 23e or 28a-f show	ai Dir	10e. Street and Number 9254 Cherry Lane			10f. Zip Code 20708		US	. Citizen of What Co A	intry?
30	uid be filed within 72 hours after death with the Marylan fental Hygiene. rked other then "neturel", or items 23e or 28a-1 show tic event, the Medical Examination and be confilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1,∑Yes 2 □ No If Yes, Give	lf 1	as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
3	2 hour	edt	15. Decedent's Edu	Year or Dates: 143—		ent's Usual Occup	ation	16	Wh11 b. Kind of Business/I	
21215-0036	within 72 ene. then "ne	Completed	(Specify only highest graded (Specify only highest graded) Elementary/Secondary (0-12) 12	Ge completed) College (1-4or 5+)	(Give k	ind of work done of O NOT use retired	during most of wor	king	ailroad	idastry
	Hygi Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)		CONDOC	JOR	18. Mother's Nar	ne (First, Middle, Ma		
yland	2 should be and Mental Is marked eumetic ev	To B	Emery Henderson				Carrie E	elkey		
Mary	2 should and Men Is marke eumetic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing	Address (Street	and Number or Ru	ıral Route Number, C	City or Town, State, Z	ip Code)
	ロモトラ		Linda Bingham/ Ste			Symphony	Lane Ga	mbrills,	MD 21054	
animore,	Pages 1 lent of H nt: If itel ry or oth		20a. Method of Disposition 1	Removal from State	metery, crema	ition (Name of atory or other place onal	1		c. Location - City or 1	
משובו	permit. Pages 1 and Department of Heall Importent: If item 2 eny injury or other 2005.		21. Signature of Funeral Service Licens		22.	Name and Addre	ss of FacilityRob	ert E. Ev	ans Funera	1 Home
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	lications that caused the death, ne cause on each line.						Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a		, Colo	n, Me	alignai	y 7	Onset and Death 2 m oS
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a conseque	ence of):					
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09/90	cate be o	Medical		d						
O. BOX 0	death e atter	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the second 2 □ Fetal of the second 2 □ Unknown	death 3 □E	Ectopic pregnancy Other (<i>specify</i>)			23d. Date of delin Month	rery Day Year
ras, r	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions co.	ntributing to death but not resul	lting in the und	derlying cause giv	en in Part I.		cco use contribute to	the cause of death?
Record	The law ate has b page 2 s	Completed						24a. Was an autopsy performs	d? death?	opsy findings available ompletion of cause of
VITai	ysiclen: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
ō	S 5	2	1 ☐ Yes 2 ☐ No		ER/Outpatient		4 Hoursing		ce 6 □Other (Spec	ify)
Sion	ending Ph lath. or: After th	ation;	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	/ at k? Yes 2 □ No	28d. Describe how	injury occurred	
Ä	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certificati	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify))			City or Town, S		
	ne Hospi 24 hou se Funer detely fill	edical	29a. Certifier 1	sician: To the best of my know ner: On the basis of examination and manner stated.	vledge, death of investigation and/or investigation and/or investigation and/or investigation and or investigation	occurred at the tinestigation, in my o	ne, date and place pinion, death occu	, and due to the causered at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
,	To the within To the comp	M	29b. Signature and title of certifier	Kundet.	no	29c. Licens	onumber 003671	6 6	Date signed (Month	Day, Year) 5 2005
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	rint) Chora	14 /2	10 6	aurel	5,2005 , Md.
ı	Sta Registr		31. Date filed (Month_Day_Year)	32. Rustrar's Signatu	ure	1	1 64			

State of Maryland / Department of Health and Mental Hygina () 5 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 5:00 PM JOSEPH JOHN HOLLENCZER, JR AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 804 MASON ROAD STEVENSVILLE
If Under 1 Year If Under 24 Hrs. **OUEEN ANNE'S** 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Director 218-76-3540 08/21/1957 VIRGINIA 47 Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examinat must be notified at 1 ☐ Yes 2 No Director PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15554 PEACHWALKER DRIVE 20716 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 CARPENTER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH JOHN HOLLENCZER, SR 2 VIRGINIA BACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trat once. MRS. LINDA OLIVER/SISTER 804 MASON ROAD STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 08/07/2005 STEVENSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.

106 SHAMROCK ROAD CHESTER, MD 21619

enter the mode of duing such as cardiac or respiratory arrest.

Approximate romas mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrely one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Pnysician Colon 00 X disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause for underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 2 2 No 1 Yes Physician: 515/215 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 2 1 🗌 Yes 2 No Residence 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attanding 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gertified 30. Name and ddre who completed cause of death (Item 23a) (Type, Print) Kenn 900 Destigite

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Johnson Jennie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 0 0 5 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Jennie Delores Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 2 F 264-36-0509 Director 09/30/27 Miami Florida Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event. Its Medical Examinar must be notified at 1 Yes 2 □ No Completed by Funeral Director M.D. Hyattsville Prince Georges 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7008 Freeport Street 20784 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If item 27 Is marked other than College (1-4or 5+) 6th Environmental Svc. Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS LABIN SMITH LILLIAN DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dollie Spriggs / Daughter 7008 Freeport St. Hyattsville MD 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of t
Importent: If ite
any Injury or ot
once. 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 8/15/2005 Clinton, MD Resurrection 21. Signatur Funeral Service Licensee Redese Professional Funeral Service 3605 14th St. NW. Washington DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ileart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, by Physician/Medical Examiner burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2D No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZX No 1 Inpatient 2 EP/Outpatient 3 DOA Certification; To this 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I filled 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

Registrar

Danyel

31. Date filed (Month, Day, Year)

2 2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 20051 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician 15, Jackson August 2005 6:21 p.m. Cecelia Agnes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 45837 Lord Baltimore Way Lexington Park St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 65 216-40-6067 11, 1940 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 le marked other then "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director St. Mary's Lexington Park Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number with 45837 Lord Baltimore Way 20653 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 le marked other then "natural", or Ita 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Bus Attendant Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Henry Bond Mary Cecelia Bond ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Lawrence / Niece 11715 Glen Abbey Court, Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Charles Memorial Gdns. 8-22-2005 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature Juneral Security Capter Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final .unc **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) fension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed bubeles and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Year in the past 12 months? Month cate has been signed by the atterpage 2 should be detached for 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 res 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2010 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death | Check only one | Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA Division of this. 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 Tes 2 No death. 2 Accident investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical ters. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exam To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 37767 Market Drive, Charlotte Hall, Maryland 20622 Manoj Panwala, M.D., 31. Date filed (Month, Day, Year) AUG 18 2005 égistrar's Signatu State

Registrar

State of Maryland / Department of Health and Mental Hygien 27880 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8 Physician 2005 Delores Naomi Johnson 4:40 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🕏 F 220-38-1269 68 Yrs. 5-18-1937 Washington, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County th and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 23e-1 show treumatic event, the Madical Exercit art must be notified at 1 ☐ Yes 2 No Director MD St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21361 Cambridge Avenue 20653 United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Sylvester Young Jeannette Elizabeth Parker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a James Johnson/ Husband P.O. Box 188 Loveville, Maryland 20656 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Immaculate Heart 8-23-05 Lexington Park, MD ^ 4 ☐ Donation 5 ☐ Other, (Specify) 21. Signature of Funer Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Simons M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRY THMA 1INUTES Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIOVASCUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit MABETES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title DO062937

DHMH 17 Rev 1/2001

State

Registrar

lospitm.

ST. MARY'S

25500 POINT LOOKOUT Rd, LEONIETOWN, ZOLOSO

f person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

SVOSODA

AUG 1 8 2005

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () 5 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 10:10 AM Annie A. Key 406 UST 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Jan. 22, 1908 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ XF 97 Yrs South Carolina 122-18-2515 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?? is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Nedical Exart at must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Mitchellville Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 United States 10208 Forestgrove Lane Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 TNo If Yes, Give 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 Tes 2 No Specify: Specify: If Yes, Give Year or Dates: **Black** 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Int: If Item 27 is marked other than " Baltimore, Maryland 2121 Elementary/Secondary (0-12) 7th College (1-4or 5+) Domestic Worker Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Albert Ferguson Mary Stinson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other traignes. 10208 Forestyrove Lane, Mitchellville, MD 20721 Joyce A. Key - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/9/2005 Ft. Lawn Cemetery Ft. Lawn, SC * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer I Service Licensee 22. Name and Address of Facility Stewart Funeral Home OWN Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, repart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (a se (Final disease or c dition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physicisn Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 90 1' Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performedia 1 Yes 2 No 1 ☐ Yes 2 100 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA this 27. Man er of eath Day of Injury (Month, Day 28b. Time of 28c. 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the Certification; After 1 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title certifier 29d. Daye signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Box 68760

31. Date filed (Month, Day, Year)

Kovalo

MIK

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 20 0 5

		1 - State Ce	artment of Health and Mental Hyg rtificate of Death	ie 2e 0 0 5 2 7 8 8 2
Physic /Med Exam	lical	Decedent's Name (First, Middle, Last) Martha Janet Kirk 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month A 4 4 5 f	Day Year
Funera Directo	I	5 ACRED HEART 5. Social Security Number 6. Sex 1 M 2⊠F 7. Age (In yrs. last birthday) Yrs.	CUMBERLAND If Under 1 Year If Under 24 Hrs. 8 Date of Birth	ALLEGANY 9. Birthplace (State or Foreign Country) Country West Virginia
e Maryland Sa-1 show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD. Allegany Barton	ocation	10d. Inside City Limits 1 ☐ Yes 2X No
ath with th	Funeral Director	10e. Street and Number 18609 Takoma Drive	10f. Zip Code 1 21521	og. Citizen of What Country? United States
paritimities in the state of the source of the source of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Examiner matter milling an any injury or other traumatic event, the Modical Examiner matter milling and once.	þ	1 Never Married 2 Married 1 Yes 2€ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XXNo Specify:	14. Race - American Indian, Black, White, etc. White Specify:
led within 72 lygiene.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4or 5+) HO	kind of work done during most of working DO NOT use retired) memaker	16b. Kind of Business/Industry HOUSEWORK
y larru	To Be	17. Father's Name (First, Middle, Last) William E. George	18. Mother's Name (First, Middle, M Janet Power:	S
C, Wall			ng Address (Street and Number or Rural Route Number, 10 Takoma Drive, Barton, Ma	aryland 21521
mil. Pages partment of I portant: If its y injury or of		1 🗷 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)	ill Cemetery 08/16/ 2005	20c. Location - City or Town, State Barton, Maryland
permit. Departition in promition any injury injury.) 7. Wage Lal 1	2. Name and Address of Facility Boal Fune: 11 Church St., Westernport	t, Maryland 21562
Physiciar /Medica Examiner		23a. Part 1. Enter the disease or complications that caused the death Do not ent shock, or heart failure. List only one cause or sach line. Immediate Cause (Final disease or condition resulting in death) Due to a a consequence of):	refrine mode of dying, such as cardiac or respiratory arrespond to the such as	Approximate Interval Between Onse and Death
cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any country that included events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of): d		
The Color of the death certificate be executed. The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit.	hysician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
w requires that been signed to should be det	by P	Part II. Other significant conditions contributing to death but not resulting in the u		acco use contribute to the cause of death? s 2 □ No 32 Probably 4 □Unknown
	e Completed	25. Was case referred to medical		prior to completion of cause of death? No 1 Yes 2 No
ng Ph fter th meral	Certification; To B	examiner? 1 Yes 2 No 1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending investigation 28a. ate of Injury (Month, Day Year) 1 Accident Injury (Month, Day Year)		nce 6 □Other (Specify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge death	City or Town	
o the Hos Ithin 24 h o the Fun ompletely	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Certifying Physician: To the best of my knowledge, death and manner stated.	vestigation, in my opinion, death occurred at the time, da	ite and place, and due to the cause(s)
F ≱ F 8		· (usting)	D15463 A	Date signed (Month, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a) (Type, \$\int K_1 M_1 \text{\$\text{\$O\$} main \$\text{\$f\$} \text{\$\text{\$\text{\$\text{\$V\$}}} \$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitit{\$\text{\$\text{\$\text{\$\text{\$\text{	aport, MR 215602	U '
Regis	tate trar	AUG 1 5 2005	A - 04 -	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygion 15

			1 - For State Registrar	State of Ma	irytanu /		tificate of	Death	vieritarriy	Reg. No		21000
	Dhuaisi		1. Decedent's Name (First, Middle, La	ist)	-				2. Date of D	Da	v Year	3. Time of Death
	Physici: /Medic		William P.						Augus	t 9,	2005	4:35 A ^M
	Examin		4a. Facility Name (If not institution, given	re street and number)				or Location of Death	1		. County of Dea	
			Casey House 5. Social Security Number 6.3	Sex 7. Age	(In yrs. last	hirthdayl	RockV		8 Date of Bi		Montgome	
	Funeral Director		577-05-0921	1 M 2 F		5 Yrs.	Months Days		8. Date of Bi (Month, D April	24,	1910 N	thplace (State or Foreign ountry) New York
land	A H		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
Mary	-f sh	tō	Maryland Montgom	ery	Sil	ver S	pring					1 X Yes 2 □ No
h the	r 28a Inotii	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	ountry?
th wit	23a c	aiD	14508 Homecrest	Road			2090	6		U.	S. A.	
r dea	sme;	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit	
ours afte	Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23s or 28s-f show any Injury of other treumstic event. The Medical Examinar must be notified at once.	i by Funerai	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 XN If Yes, Give Year or Dates:	lo	1	☐ Yes 2 💢 No	Specify:			Specify: W	nite
72 h	netu dical	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	10	(Give I	ent's Usual Occu	e during most of wor	rking	16b. K	and of Business	Industry
Mithin 6	then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT use retir Llor	0 a)			Clothin;	2
# pell	Hygie thar i		17. Father's Name (First, Middle, Las.	t)			101	18. Mother's Nan	ne (First, Middle			
d be	ked o	To Be	Harry Kurtz					Rose L	evy			
shou	mar umat	-	19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailin	g Address (Stree	et and Number or Ru	ıral Route Numl	oer, City o	or Town, State,	Zip Code)
and 2	alth a		Leona S. Kurtz -	Wife				st Road,	Silver			
98 1	of He		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 \$	▼Removal from State	ceme	etery, crem	sition (Name of natory or other pl		Date		ocation - City or	
Pag	ant: I		`4 □Donation 5 □ Other (Special	<i>fy</i>)	King	Davi	Ld Mem.	Garden 8/	12/05	Fal	1s Chur	ch, Virginia
permit. Pages	Depart Import any In		21. Signature of Funeral Service Line	114	imes	£ 22	lward Sa 191 Rock	gel Funer ville Pik	al Dire	ctio	n, Inc.	land 20852
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. D	Do not ente	er the mode of dy	ring, such as cardiad	or respiratory	arrest,	,	Approximate Interval Between
Pł	nysician		Immediate Cause (Final disease or condition		der Ca	ncer						Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	a consequen	ce of):						
	Karrinici	1	Sequentially list conditions.	b. — Due to (or as a	a consequen	ce off:						
pet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequen	oo orj.						
, execu	ng physician and as the burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or as a	a consequen	ce of):						
ficate be ex	/sicia	cail		d								
oo/ou, rificate be executed	as th	ledi	LE FEMALE									
	tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnan	су		ŀ	23d. Date of de Month	livery Day Year
e dea	the at hed to	Physician/Medicai	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at 9□Unknown	time of death	n 5□	Other (specify)				WOITH	Day Toan
hat th	ad by		Part II. Other significant conditions	contributing to death bu	ut not resultin	na in the ur	nderlying cause o	liven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Physicien: The law requires that the death ce	n. After this certilicate has been signed by the attendir funeral director, page 2 should be detached for use	ed by							1 🗆	Yes 2	□ No 3 🏋 Pi	robably 4 Unknown
a v s	s bee 2 sho	Completed							24a. Wa:		24b. Were at	utopsy findings available completion of cause of
T Pd	ate ha	mo:		-					peri 1 ☐ Yes	ormed?	death?	
	ctor, I	Be	25. Was case referred to medical examiner?					26. Place of Dea				
Physic	this co	2	1 ☐ Yes 2 🔀 No	Hospital:			1 3LI DOA					cify) Hospice
or ding F	After funera	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28	b. Time of Injury	28c. Inj W	uryat ork? ⊒Yes 2 ⊒No	28d. Describe	how inju	ry occurred	
ttsno	after death. Director: A d in by the fu	licat	2 Accident investigation 3 Suicide 6 Could not	be One Blace of Inju	ırv - At home	farm, stre			28f. Location	(Street ar	nd Number or Ri	ural Route Number,
a or a	s after	Certification:	4 Homicide determined	building, etc	c. (Specify)				City or To	own, State	e)	
the Hospital or Attending	within 24 hours after death To the Funerel Director: completely filled in by the	edical (Physician: To the best of aminer: On the basis of and manner sta	examination							
To th	within To th comp	Me	29b. Signature and title of certifier	ing			29c. Licer	nse number		29d. Da	te signed (Mont	th, Day, Year)
ì	+		Collect	7/11				41218		Αu	igust 9,	2005
	1		30. Name and address of person who					.11 Road,	Rockvil			
	. Sta		31. Date filed (Month, Day, Year)		ar's Signature							
	Registi	rar	AUG 11 2	2005 Senew	15	A STATE OF THE PARTY OF THE PAR	A Second					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 1005 27884

			For State Registrar	tate of Maryland		rtment of H Fificate of L			eg. No.	21004
	*		Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physicia /Medic		ANDERSON KE	ARNEY, JR.				August	7, 2005	7:15 A M
}	Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or			4c. County of Dea	
			Washington Adv				kvill			mery Co.
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day		rthplace (State or Foreign ountry)
	Director		241-52-5180 X MUSUAL Residence of Decedent	/1				Nov. 2	26, 1933	N.C.
	yland Now		10a. State 10b. County	10c. City, 7	Town or Loc	ation				10d. Inside City Limits
	a-fs	ctor	Virginia		Richn	nond				1 V Yes 2 No
	3a or 28	i Dire	10e. Street and Number 1202 North 1st St	reet		10f. Zip Code 2321	9	1	I0g. Citizen of What C	
036	be filed within 72 hours after death with the Maryland tal Hygiene. 4 other then "natural", or Items 23a or 28a-f show event, the Medical Exeminat must be inclifted at	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		/as Decedent of Hi Yes, specify Cuba	ispanic Origin In, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh Specify: B 1	te, etc.
21215-003	in 72 ho n "natur Aedical	Completed	15. Decedent's Education (Specify only highest grade co.	mpleted)	(Give k	ent's Usual Occupa ind of work done of O NOT use retired	durina most oi	f working	16b. Kind of Business	s/Industry
212	should be filed within of Mental Hygiene. I marked other then metic event, Ite M	lmo	7th Grade	College (1-4or 5+)	ة ا	borer			Self	
힏	be filed ital Hyg id otha evant,	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle,		
<u>Xa</u>	should band Ment and Ment markac umetic e	인	Anderson Kearney					mma Pirio		
Maryland	is 1 and 2 should of Health and Men itam 27 Is marka other traumetic		19a. Informant's Name/Relationship (Type. Morris Kearney (or Rural Route Numbe. Stroot Di		<i>Zip Code)</i> Va. 23219
	1 and Health am 27 thar t		20a. Method of Disposition	20b. Plac	ce of Dispos	ition (Name of			20c. Location - City o	
altimore,	Pages nent of int: If its iry or o		N Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	oval from State Pin		atory or other plac 'ove Cer	Α	gust 12,2005	Halifax,	
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	. The	22.	Name and Addres	ss of Facility	Rollins ce, N.E.	Funeral	Home, Inc.
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complex of the com	ons that caused the death.	Do not ente	r the mode of dyin	g, such as ca	rdiac or respiratory ar	rest, 20019	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	TOXIC Metab	olie	Enceph	alope	atly.		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer			,	nl Faile		
	Examiner.	16	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	nce of):	eule	rava	ne taile	ly	
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Sopsi	0					
<u>,</u>	execu n and ial-tra	Еха	that initiated events c resulting in death) Last	Due to (or as a conseque	nce of):	1	0	0		
58760,	eath certificate be executed attending physician and for use as the burial-transit	edicai	d	Bilo Fores	1	Bucem	nal	Proumu	ma	
_	ntifica ing ph		IF FEMALE:							1
Вох	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal de	eath 3 🗌	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
о. О.	uires that the de signed by the a Id be detached f	Physician/M	1 Type 2 TNo	4☐Pregnant at time of deal 9☐Unknown	th 5∐	Other (specify)				
	that the ed by detac	/Ph	Part II. Other significant conditions contrib	uting to death but not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
sp.	uires n sign lid be	d by	AIDS. (Tormuse	e ST	orsa).		1 🗆 Y	es 2. ŽTNo 3. ∏. F	Probably 4 Unknown
Vital Records,	e law requir has been si je 2 should	Completed	TYPO IL I	siabotes 1	Halle	tus.		24a. Was autop		autopsy findings available completion of cause of
œ =	The page	Com	Panphor	al Casu	ler	disens	\$ · · ·	perfor 1 ☐ Yes	med? death? 2≦No 1☐Ye	37
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medi I examiner?	nital:		Oth	05	f Death (Check only or		
	Physical this call dir	۲: ۲:	1 ☐ Yes 2X No Hosp 27. Manner of Death	ınpatient 2 □ Er	R/Outpatient 8b. Time of	The same of the sa	4 🔲 Nursi	ing Home 5 Resid	ence 6 Other (Sp ow injury occurred	ecify)
on	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injun Wor M 1	k? Yes 2 □ No		ow injury cocurred	
Division of	Attan sr deal ector: by the	Certification:	2 Cuiside 6 Could not be	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	itreet and Number or F	Rural Route Number,
ā	tal or rs afte al Dir ed in	Cert	4 - Hornicus	building, etc. (Specify)				0.0, 0. 70		
	To the Hospital or Attanding Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as	edical		an: To the best of my knowle On the basis of examination and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	- /		29d. Date signed (Mor	
)	11					4	7867		8/8/05	
			30. Name and address of person who comp							
	Hr.		Oney/Zuniga, M.[4701 Ra	pdol	h Road	Roc	kville, N	Maryland	20852
ţ.	Sta Registi		31. Date fig 1 Part 1 02. 2005	o strait signati						

be Type of Fillit in black indefible link. Ensure All copies Are Legible	-		_	
State of Maryland / Department of Health and Mental Hyge 15	2	78	38	1
Cartificate of Dooth				

		1 - For State Registrar	State of Marylan		ificate of L			Reg. No.	00 2	1000
Dhusia		1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	Day	Year	3. Time of Death
Physic /Medi		Elizabeth Ann Ko					August	7, 2	005	11:30 A ^M
Exami	ner	4a. Facility Name (If not institution, give				Location of Deat	h		ounty of Death	
		802 Coxswain Way 5. Social Security Number 6.	, Apt. 201 Sex 7. Age (In yrs.)		Annapol:	1S If Under 24 Hrs	8. Date of Birt		nne Aru	INCEL lace (State or Foreign
Funeral Director			1 M 2 XXF 73	Yrs.	Months Days	Hours Min.		v Yearl	Cour	rland
land ow		10a. State 10b. County	10c. Cit	y, Town or Loca	ation				1	0d. Inside City Limits
Mary	to	Maryland Anne Ar	undel	Annapo]	lis					1 ☐ Yes 2 XNo
r 28e	irec	10e. Street and Number	<u> </u>	111110	10f. Zip Code			10g. Citize	n of What Cour	ntry?
238 o	al D	802 Coxswain Wa	y, Apt. 201		21	401		US	SA	
r dea	iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puer	specify Yes or No- to Rican, etc.)	. 14	. Race - Americ Black, White,	
IIIU X IX I 3-0030 be filed within 72 hours after death with the Maryland tal Hyglene. d other then "natural", or Items 23a or 28e-1 show event, the Madral Examinat the natified at	by Funeral Director	1X Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		Yes XX No	Specify:			pecify: Wh	ite
72 ho	sted	15. Decedent's E (Specify only highest gr		16a. Decede	nt's Usual Occupa	ation during most of wo	rkina	16b. Kind	of Business/Inc	dustry
od within glene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	O NOT use retired	0		Ameri	.can Aut	comobile
d CIC		12th	41	Exec	cutive S	ecretary			iation	
= 0 = 5 ≥	Be	17. Father's Name (First, Middle, Las					me (First, Middle, erine C.			
should be a marked o	2	Michael Kor		10h Mailing	Address (Street		ural Route Numbe			Code
- C1 (0 - 0		Katherine E. Kor					. 201, A			
- 5 8 5		20a. Method of Disposition			tion (Name of atory or other place		Date	20c. Loca	tion - City or To	own, State
Definition of the partment of Heal Importent: If the many injury or other once.		1 ☐ Burial 2 X Cremation 3 [14 ☐ Donation 5 ☐ Other (Special Control of Con	Memovai irom State	alas Cre		8-9-	05	Fdae	water,	MD
permit. Pages 1 e Department of He Importent: If Item any injury or othe		21. Signature of Funeral Service Lice				1	eorge P.			
Page 1		Ident & Elect		29	73 Solo	nons Isl	and Rd.	Edgew	ater, N	D 21037
24.1		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death	h. Do not enter	the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
Physician		tmmediate Cause (Final disease or condition	Emphy	150,W	10					Onset and Death
/Medical		resulting in death)	Due to kr as a con-	uence of):	11					1
Examiner		Sequentially list conditions.	b							
p is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause Orssass or injury	Due to (or as a conseq	juence of):						
icate be executed physician and site burial-transitions	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	mence of).						
be ey lolan buria			225 (5) (5) 25 255 (55)	,007.00						
ortificate be e	Medical		_ d							
+ 2.10		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					236	d. Date of delive	ery
death cer attendir d for use	Cial	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		ctopic pregnancy Other (specify)				Month	Day Year
at the d by the etache	Physician/	9 ☐ Unknow(9□ Unknown							
res that the de signed by the a	by P	Part II. Other significant conditions	contributing to death but not res	ulting in the und	derlying cause give	en in Part I.			^	ne cause of death?
w require							101	∕es 2□	No 3 P ob	ably 4 Unknown
ne law ra s has be ge 2 sh	Completed						24a. Was	SV 🔨	24b. Were auto	psy findings available mpletion of cause of
	E OC						perfo 1 ☐ Yes	rmed?	death?	
ysiclan: The law requires tysiclan: The law requires tis certificate has been signed director, page 2 should be (Be (25. Was case referred to medical examiner?					ath (Check only o	nle)		
Physic Physic this or	2	1 Yes 25 No		ER/Outpatient		4 🗆 Italiang i	lome 5 A sid			y)
lor Attending Physelfer death. Director: After this din by the funeral di	on:	27. Manner of Teath 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. D scribe h	now injury o	occurred	
uttend death ctor: /	icat	2 Accident investigate 3 Suicide 6 Could not	be 380 Place of Injury At he	omo farm etras		195 2 10	28f Location /5	Street and I	Number or Rura	ıl Route Number,
or Atten efter deat Director:	Certification:	4 Homicide determine	building, etc. (Specif	(y)	st, factory, office		City or Tov		1011001 01 11010	in riodio i vambor,
To the Hospitel or Attending Physicien: within 24 hours effer death. To the Funarel Director. Affer this certifical completely filled in by the funeral director,	edical C	29a. Certifier 1 Check only one) 1 Medical Exa	Physicien: To the best of my knouncer: On the basis of examina and manner stated.	owledge, death a ation and/or inve	occurred at the tinestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. o the cause(s)
To the H within 24 To the Fa complete	Me	29b. Signature and title of confier	// ^		29c. Licens	e number		29d Date	signed (Month,	Day, Year)
⊢ ≯ ⊢ 0		Voto (V	rel pol		3	5494		8/8	1/2005	
		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, P	rint)					
		Steven Resnick,	_			l Ctr	Annapoli	s. MD	21401	
St	ate	31. Date filed (Month, Day, Year)	32. Finistrar's Signa	ature	_			.,		
Regist	trair	AUG 1 0	2005	BA	man de la company de la compan					
DHMH 17 Rev 1/	2001			1						

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State of Maryland / Department of Health and Mental Hygian 05

		•	for State Registrar	otato or marytana	Certificate of	Death	Reg.		.,000
	Physici	an	1. Decedent's Name (First, Middle, Last				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		JAY BURNELL	KUNKLE			AUG. 7	2005	12:00 P M
	Examin	er	4a. Facility Name (If not institution, give 12652 PEACH LANE	street and number)	CORDO			4c. County of Death TALBOT	
	Funeral Director		212-44-0990	x 7. Age (In yrs. last	t birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye MARCH 3,	ear) Cou	place (State or Foreign ntry) NSYLVANIA
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Fown or Location				10d. Inside City Limits
	8e-f eh	Funeral Director	MD TALBOT	СО	RDOVA				1 Yes X No
	with the	Dire	10e. Street and Number		10f. Zip Code	1.605	10g.	Citizen of What Cou	ntry?
	ns 23	era	12652 PEACH LANE	12. Was Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cub	21625 Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ameri	can Indian,
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ehow he Madical Examiner must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	If Yes, sp <i>ec</i> ify Cub		Rican, etc.)	Black, White,	etc. ITE
5	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occu (Give kind of work done	during most of working	ing 16t	. Kind of Business/Ir	dustry
121	within ene. then '	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	ASSISTANT PI	•		EDUCATION	
g 5	filled Hygin other	Be Co	17. Father's Name (First, Middle, Last)		11001011411		(First, Middle, Mai		
<u>la</u> n	uld be Aental rked tic ev	To B	ROBERT F. KUNKLE			KATHR	YN MILLER	L	
, Maryland 21215-0036	and 2 sho alth and N 127 le ma er treuma		19a. Informant's Name/Relationship (7) MARTHA AC KUNKLE		19b. Mailing Address (Stree 12652 PEACH	LANE, COR	DOVA, MD	ity or Town, State, Zij 21625	Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or items 23a or 28e-f ehow any injury or other treumatic event, the Medical Examinar must be nutified at once.		20a. Method of Disposition 1 Burial 2 Xcremation 3 F 4 Donation 5 Other (Specify)	Removal from State CHESA	e of Disposition (Name of etery, crematory or other plane of the CREMAT LLC	ce)		Location - City or To	
Balt	permit. Departr Importe any inji		21. Signatule of Funeral Service Licens	Hollentin	FELLOWS, HI				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.				. 1101	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Lung Ca	New			4	Onset and Death White
	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):				
		ē	if any, leading to immediate	b Due to (or as a consequen	ice of):				
	outed id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury	с.					
Ö,	e exer		resulting in death) Last	Due to (or as a consequen	nce of):				
68760,	ertificate be executed ing physician and e as the burial-transit	Medicai		d					
Вох	ath co	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de 4□Pregnant at time of death	eath 3 Ectopic pregnance	у		23d. Date of deliver	ery Day Year
o.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
rds, P	The law requires that the de- ste has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the underlying cause gi	ven in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Seco	The law requirestate has been sipage 2 should I	Completed					24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
T T		e Co	25. Was case referred to medical				1 Yes 2		2□ No
<u>=</u>	Physiclen: this certific	To Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3□ DOA Ot	26. Place of Death		6 ☐Other (Specif	(v)
Division of Vital Record	Attending Phy ir death. ector: After thi by the funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Bb. Time of 28c. Injury Wo	The second secon	28d. Describe how i		,,
Divis	el or Atter s after des il Director id in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rura tate)	il Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death occurred at the to a and/or investigation, in my	me, date and place, a opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29c. Licen	se number	29d.	Date signed (Month,	Day, Year)
			1 pma	Jun	03	1885	8	18/02	
	OVV		DAVID H. SMITH,			SUITE 5. E.	ASTON. MD	21601	
4	Sta	te		32. P gistrar's Signature	-				
	Registr		31. Date filed (Month Day Year) 8 2	005 Alexan L	4 Spark				

St. Mary Source Nursing Center Leonardtown St. Mary Source St. Mary St. Mary Source St. Mary St. Mary Source St. Mary Source St. Mary Source St. Mary St. Mary Source St. Mary St. M	3. Time of Death
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Count St. Mary's Nursing Center Funeral Director Funeral Director 5. Social Security Number 220—84—2618 1 Mary's Nursing Center 5. Social Security Number 220—84—2618 1 Mary's Nursing Center 6. Sex 75 yrs. Months Days Hours Min. Mary 153, Yang 30 Usual Residence of Decedent 10a. State 10b. County Mary ST. Mary's 10b. County Mary ST. M	2005 11:40A M
S. Social Security Number 220—84-2618 1 m 2 m 7. Age (In yrs. last birthday) 1 m 1	unty of Death
Director Director	. Mary's
10a. State MARY I S 10b. County ST. MARY S 10c. City, Town or Location CHARLOTTE HALL 10a. Street and Number 10b. County ST. MARY S 10c. City, Town or Location CHARLOTTE HALL 10a. Street and Number 10b. Citizen or CHARLOTTE HALL 10a. Street and Number 10b. City Town or Location CHARLOTTE HALL 10a. Street and Number 10b. City Town or Location CHARLOTTE HALL 10a. Street and Number 10b. City Town or Location CHARLOTTE HALL 10a. Street and Number 10b. City Town or Location CHARLOTTE HALL 10a. Street and Number 10b. City Town or Location CHARLOTTE HALL 10a. Street and Number 10b. City Town or Location CHARLOTTE HALL 10c. City, Town or Location CHARLOTTE HALL 10c. City, Town or Location CHARLOTTE HALL 10a. Street and Number 10b. City Code 10c. City, Town or Location CHARLOTTE HALL 10c	9. Birthplace (State or Foreign
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19c. Place of Disposition (Name of cometery, crematory or other place) 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19c. Place of Disposition (Name of cometery, crematory or other place) 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location	of What Country?
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JILL POTTS/DAUGHTER 25565 CHAPTICO OVERLOOK WAY, CHAPTICS 20b. Place of Disposition (Name of commetery, crematory or other place) 20c. Location of commetery, crematory or other place)	name)
20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location (Name of cometery, crematory or other place)	wn, State, Zip Code)
Centretery, Crematory of Other place)	
E 5 3 AZIDOR	on - City or Town, State
TRINITY MEMORIAL GARDENS 2005 WALDOR 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee P.A., 30195 THREE NOTCH RD., CHAD	LS FUNERAL HOME,
23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Approximate 0622 Interval Between Oriset and Death
/Medical resulting in death) Due to (or as consequence of): Sequentially list conditions, b. Due to (or as consequence of):	47 8
Sequentially list conditions, if any, basening to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	yss.
ale be de ale be different the burn of the	U
X 5 5 7 2 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. D	Date of delivery Month Day Year
See the second of the second o	ontribute to the cause of death?
To yes 2 le No 1 Yes 2 le No 24a. Was an autopsy performed?	b. Were autopsy findings available
	prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
To be a compared to medical examiner? 1 Yes 2 8 No 25. Was case referred to medical examiner? 1 Yes 2 8 No 25. Was case referred to medical examiner? 1 Yes 2 8 No 25. Was case referred to medical examiner? 1 Yes 2 8 No 25. Was case referred to medical examiner? 1 Yes 2 8 No 25. Was case referred to medical examiner?	
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building, etc. (Specify)	mber or Rural Route Number,
29a. Certifier (Check only (Ch	manner as stated. e, and due to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signature	
	ned (Month, Day, Year)
30. Name and address of berson who completed dause of death (Item 23a) (Type, Print) TAMES P. JAPPOF 2/025 THREE NOTCH PR. HOLLYHOOD NO. 20026	ned (Month, Day, Year) - 11-05
JAMES P. JARBOE, 24035 THREE NOTCH RD., HOLLYWOOD, MD 20636 State State Registrar ALIC 1 2 2005	and the same of th

State of Maryland / Department of Health and Mental Hygien 005

27888

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaer **Physician** 1130aM 2005 Walter Leon Lewis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) April 16,1925 If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**∕2** M 2□ F 80 Maryland Director 216-22-7806 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other traumetic." with 21740 48 Randolph Ave. U.S.A Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) State Highway Maintenance 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna M. Over UnKnown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 48 Randolph Ave. Hagerstown, Md. 21740 (Son) Troy D. Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 15, 1 Burial 2 Cremation 3 Removal from State Cedar Lawn Memorial Hagerstown, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. DAVIS MOIS J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Atter 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1724585 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE Hogerstown Maryland 32. Resistrar's Signature 31. Date filed (Month, Day, Year) AUG 15 State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie pen 05 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician LENNON 3.31 EARL AUGUST 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner saltimore he Johns HOPKINS Hospita tu Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M 2 TE Director 213-80-4840 APRIL 16 1961 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State rel', or Items 23a or 28a-f show Examiner aust be notified at tX☐Yes 2☐No Charles Waldorf Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12153 Ell Lane #48 20602 U.S.A. iiled within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private 11th permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 I e marked othe eny injury or other traumatic event, 9R68. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Oliver Mary Savoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3008 Gallery #35 Waldorf, MD 20602 Lisha Lennon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) 08-17-2005 Landover, MD Harmony Memorial 22. Name and Address of Facility JB Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd LAndover, MD 20785 D ON 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** MASSINE GASTROINTESTINAL HEMORRHAGE 6 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INTRAVASCULAR COAGULATION DISSEMINATES 6 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal the F FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown SCLEROBERMA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CREST SYNDROME performe 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: in by the 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a

To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 241 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie RES.000 AUGUST 2005 MA 10 412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVIS COSCIDUE, JOHNS HOPKINS HOSPITHL, 600 NORTH WOLFL STREET, BALTIMORE, MARYLAND, 21287

32. Registrar's Signatur

ORIGINAL

Registrar

State

31. Date filed (Month, Day, Year) AUG 1 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 1 5 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ABRAHAM ROSS LERNER 9, 2005 August 04:40am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Yrs. Director 96 443-20-8698 Sept. 16, 1908 Missouri Usual Residence of Decedent 10c, City, Town or Location s 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5802 Nicholson Lane, Bldg. 2 Apt. 707 20852 S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after XYes 2□No Army Yes, Give 1 ☐ Never Married 2 X Married Baltimore. Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW 2 natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Physician Orthopedic Surgeon other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be fi of Health and Mental H I Item 27 Is marked ot Solomon Lerner (Unascertainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Steven D. Lerner - Son 7634 Royal Dominion Dr., Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If its 1 ∰ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) 100 Parklawn Menorah Gdns 8/10/2005 Rockville, Maryland 21. Signature of Funeral Service 22, Name and Address of Facility Edward Sagel Funeral Direction, Inc. -1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Emit disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Tyes Division of Vital Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe/how injury/occurred Hospital or Attending Natural 5 Pending death. 1 Tes investigation un Known UNKNOWW 2 Accident I hours after death unaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UN KNOWN 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Uh 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

tucia 393 Name and address of person who completed cause of

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(Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygia 2005 2789

_			For Stete Registrar					artment of F tificate of			Reg. No.		
	Physicis		1. Decedent's Name (F	First, Middle, Last)						2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Paulin	e	Aretta		Lips	itz		August			3:00 p M
	Examin		4a. Facility Name (If no	ot institution, give s	treet and number)		-	4b. City, Town, o	or Location of Dea	th	4c. Cou	nty of Death	•
			Holy C	ross Hos				Silve:	r Spring		Mon	tgomer	y
	Funeral		Social Security Num	ber 6. Sex	7. Ag		ast birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bi	th 6, 191	9. Birthp Coun	lace (State or Foreign
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	2 >	-	Usual Residence of De 10a. State	ecedent 0b. County		10c City	, Town or Lo	eation					0d. Inside City Limits
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	Ba-f.	Director	Maryland	Montgome	ery	Sil	ver S						
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	11 w	<u>a</u>	11401 Mont	icello Av	venue			209	02			USA	
	ges ges	Funeral	11. Marital Status	1	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Yes or No	o- 14. F	Race - Americ Black, White.	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mentall Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examiner must be notified at once.	by Fu	1 Never Married 3 Widowed 4 [1 Yes 2 1 If Yes, Give Year or Dates:			1 ☐ Yes 2 🔼 No		, , , , , , , , , , , , , , , , , , , ,	I	cify: Whit	
Maryland 21215-0036	72 hou	Completed		5. Decedent's Educ only highest grade			16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind o	f Business/Inc	dustry
2	12 should be filed within h and Mental Hygiene. 7 is marked other than " rraumatic event, the Mac	dr	Elementary/Second	ary (0-12)	College (1-4or 5	5+)		onenaker	1d)		Orm	Home	
7	ygier yerth	S	12					omemaker		(F) . M(1/4)			
p	be fill tal H d out	Be	17. Father's Name (Fin	rst, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden Sun	iame)	
<u>yla</u>	Men	ဥ	Henry Jo	seph Del	Lorme					ta Flor			
ar	and and is m		19a. Informant's Name	e/Relationship (Ty)	oe, Print)		19b. Mailir	ng Address (Street	t and Number or F	Rural Route Numb	er, City or To	wn, State, Zip	Code)
	1 and 3 Health tem 27 other tra		Herbert L	ipsitz /	Husband		-	1 Montic	ello Ave				
Baltimore,	item item		20a. Method of Dispos			20b. Pl	ace of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location	n - City or To	wn, State
E	Page ont of		1 ♣ Burial 2 ☐ 0	Cremation 3 □R □ Other (Specify)	emoval from State	i		em Garde	1	12/2005	Olner	, Mary	rl and
=	permit. Pages 'Department of H Important: If ite any Injury or of once.	1	21. Signature of Fune	ral Service Licen	e		22	2. Name and Address	ess of Facility H	ines Rin	oldi Fi	norel	Home
B	permii Depar Impor any Ir	5 3	+ Kan	XN	Sulto	x	_ 1	1800 Nov	Hamnehi	ro Avo C	ilvor (Spring	MD 20904
			23a. Part1. Enter the	disease, or compli	cations that caused	the death			-			эргтик,	Approximate
			shock, or heart f	ailure. List only on	e cause on each li	ne.		-,		,	,		Interval Between Onset and Death
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	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):						
	LAdimilei		Sequentially list condi	itions, b									
	ש ש	Examlner	Sequentially list condi if any, leading to immi cause. Enter Underly Cause (Disease of inj that initiated events	ediate ing	Due to (or as	a consequ	ience of):						
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0	a exe lan a	Ä	resulting in death) Las	st	Due to (or as	a consequ	ience of):						
68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical			1								
99	tifica ng ph as ti							<u> </u>					
Вох	that the death certifii ed by the attending I detached for use as	Z.	IF FEMALE: 23b. Was decedent po	regilalit	3c. If yes, outcome 1□Live birth	of pregnat		Ectopic pregnanc	**/			Date of delive	
ω.	deatl e atte d for	Cia	in the past 12 mo 1 □ Yes 2		4 Pregnant a			Other (specify)	·y			Month	Day Year
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٦.	that ned b	Completed by Physician/M	Part II. Other significa	ant conditions con	tributing to death b	ut not resu	Iting in the u	ndertying cause gi	ven in Part I.	23e. Did	tobacco use c	ontribute to th	e cause of death?
Records,	uires t signe Id be (q p	Diabe	tes Melli	Ltus					1 🗆	Yes 2□No	3 🗆 Prob	ably XXUnknown
Ö	w requir been si should	lete								24a. Was	an 24	h Were auto	psy findings available
3e	has has	m m	Hyper	tension						auto	psy	prior to cor death?	npletion of cause of
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£	Physician: this certific ral director,	2	1 ☐ Yes XXNo	·	lospital: 1 XX patie		ER/Outpatier			Home 5 ☐ Res			/)
Division of	ng P fter t nera	:io	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f 28c. Inju Wo	iry at ork?	28d. Describe	how injury oc	curred	
.0	Attending ir death. ector: After by the funer	atle	2 🗋 Accident	investigation				M 1]Yes 2□No				
<u>×</u>	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj			reet, factory, office			(Street and Nu wn, State)	mber or Rura	l Route Number,
	s aft s aft al Di	Cer					,						
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phys	sician: To the best ner: On the basis o and manner st	f examinat	wledge, deat ion and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and date and place	manner as st ce, and due to	ated. the cause(s)
	ithin o the	Me	29b. Signature and titl	le of certifier				29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year)
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	(a)		30. Name and addres							_	_		
	G.			. Gupta,		01 Ge	orgia	Print) Avenue	#220 Sil	ver Spri	ng, Mai	yland	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 0 5 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) JOAN FERNEE WEBB LOEFFLER 2. Date of Death GOK **Physician** 1540M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MICOMICO DIC 0) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9/1/191 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) Days Min England Months Hours 1 ☐ M 2 🔀 F Director 236-44-1045 85 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 351 Deers Head Hospital Rd. 21801 USA Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of al Hygiene. Lother then "naturel", or Iten 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) American Chemical Co. Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If item 27 Is marked o' Mary (unknown) Herbert Fernee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11397 Hayman Dr., Princess Anne, MD 21853 Department of Health Important: If item 27 Richard A. Webb/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State Salisbury Crematory 8/11/05 Salisbury, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21 Si nature of Fu eral Service Licensee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association any i CFSP 501 Snow Hill Rd., Salisbury, MD 21804 James of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DRSRASE **Physician** END STAGE YEAR disease or condition resulting in death) /Medical Examiner CORONARY DRSBASR YBARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSFICE 2 No 10 1 Tes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Manner of Death or Attending Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funerel C the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

AUG 1 2 2005 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

5HULAM

31. Date filed (Month

26266 ARROWNOLD

Ru

29c. License number

D53410

CT.

SALISBURY

29d. Date signed (Month, Day, Year)

8-10-05

and manner stated

32. Pogistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie?e 115

			1 - For State Registrar	State of Me	aryland / De		te of Deat			a. No.	21000
			1. Decedent's Name (First, Middle,	Last)				2	. Date of Death		3. Time of Death
	Physici /Medio		Margaret I.	Long					Aug.	Day Yea 200	5 10:48a M
	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City	, Town, or Location	on of Death		4c. County of De	eath
			607 Andrew H	Hill Road			'Arno			Anne A	rundel
в	Funeral			6. Sex 7. Ag 1 ☐ M 2 🔀 F	e (In yrs. last birtho	Months		ler 24 Hrs. 8 s Min.	Date of Birth (Month, Day,)	(ear) 9. B	hirthplace (State or Foreign Country)
	Director		216-36-9007 Usual Residence of Decedent		65 Yrs			0	ct. 6,	1939	MD
	land ow		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	Mary -1 sh	ţŏ	MD Anne	Arundel			P	Arnold			1 ☐ Yes 21 No
	r 288	Director	10e. Street and Number			10f. Zi	p Code		100	g. Citizen of What	Country?
	h with	0	607 Andrew Hil	l Road			21012			USA	•
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Dece	edent of Hispanic (ecify Cuban, Mexic	Origin? (Specif	y Yes or No-		nerican Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23a or 28a-f show the Medical Examinat must be molified at	þ	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced		No		2⊠No Speci		san, etc.)	Specify:	White
2-0	72 ho	Completed	15. Decedent's (Specify only highest		16a. De	ecedent's Usu	ual Occupation	act of working	16	3b. Kind of Busines	s/Industry
2	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+) (iii	e. DO NOT	ork done during m use retired)	ost of working			
21	il Hygier other th	Š	12			НС	omemake:			Hon	ne
nd	0 5 5 p	Be	17. Father's Name (First, Middle, La	-					First, Middle, Ma	uiden Sumame)	
3	2 should be and Mental Is marked	ဥ	James E. Har					irdie			
Ma	nd 2 st lth and 27 Is r treur		19a. Informant's Name/Relationship Charles W. Lond							City or Town, State	
	1 ar Hea mm		20a. Method of Disposition	J/Husbaria	20b. Place of Di	sposition (Na	rew Hill	ROad,		C. Location - City of	012 or Town State
ē	o O		1 ☐ Burial 2 XCremation 3 14 ☐ Donation 5 ☐ Other (Spe		Metro			Aug.		Baltimore	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Furneral Service Lie	censee Alla		22 Name a	nd Address of Fac	ins P Z	Sever	rna Dark	Funoral Homo
			23a. Part I. Enter the disease, or co	omplications that caused	the death. Do not	enter the mo	de of dving such:	as cardiac or re	espiratory arres	na Park,	MD 21146 Approximate
b			shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lir	10.			- 1 :		·,	Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	a		ncer	Met	restati	1 C		2 years
P	Examiner			Due to (or as	a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C.							
o,	an an rial-tr		resulting in death) Last		a consequence of):						
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d.							
	ng ph	Med	IF FEMALE:								
Вох	eath ce attendii I for use		23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 ⊟Ectopic p	regnancy			23d. Date of d	
О. П	D D D	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown		5 🗌 Other (s)				Month	Day Year
۵.	that the	Ph	Part II. Other significant condition	s contributing to death bi	ut not resulting in th	a undarlying	cause given in Par	+1	23e Did tohar	cco use contribute	to the cause of death?
Vital Records,	law requires that the de as been signed by the 2 should be detached	d by				,	3			_	Probably 4 Unknown
CO	w rec	Completed							24a. Was an	24h Were a	autopsy findings available
Re	ө <u>г</u> ө	omp							autopsy performe	d? prior to death?	completion of cause of
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical				26 Pla	ce of Death (C	1 Yes 25	No 1 L Ye	s 2 No
	Physician: r this certificaral director, i	O B	examiner? 1 ☐ Yes 2 ☐ 50	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	tient 3 D	Other			ce 6 Other (Sp	ecify)
0	ding Ph h, After th funeral	L:u	27. Manner of Death	28a. Date of Injur (Month, Day		The second secon	28c. Injury at Work?		I. Describe how		outy
0	Attending it death, ector: After by the fune	atlo	1 Natural 5 ☐ Pending investigal	tion	, , out, might	М	1 Yes 2	□No			
Division of	l or Attena after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At home, farm, c. (Specify)	street, factor	y, office	28f.	Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
	urs af										
	To the Hospitel or Attending Ph within 24 hours after death, To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examination and/o	eath occurred investigation	at the time, date and in my opinion, de	and place, and eath occurred a	due to the caus at the time, date	se(s) and manner a and place, and du	is stated. re to the cause(s)
	To the To the Comp	Z	29b. Signature and title of certifier	1/8	h .	29	c. License numbe		1	. Date signed (Mor	oth, Day, Year)
)			tugine 11	homes /	lanin 1	מר	0000	16242	-	8/5/2	005
			30. Name and dress of person wh	ho completed cause of de		e, Print)	strak R		^		20.0
			7 7 7	- 1		60 Be	stgale R	d #30	3, 4n.	regolus, v	172 21401
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Registra	ar's Signature	Short	20				

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			1 - For State Registrar	State of Ma	arylanu		tificate of I			Jielže () () () Jieg. No.	2/034
			1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea Month	ith Day Ye	3. Time of Death
	Physicia /Medic		Beatr	ice Cecilia	Lawson	1			August	4 = 000	
	Examin	_	4a. Facility Name (If not institution	n, give street and number)				Location of Death		4c. County of E	
			SunBridge Car		- the case too	A for instruction (1)	Elkton If Under 1 Year	If Under 24 Hrs.	Data of Diet	Cecil	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las O	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day SEPT 4,	Year) 9.	Birthplace (State or Foreign Country) [aryland
	Director		212-26-9917 Usual Residence of Decedent	/	0				DELT 4,	1920 11	arytana
	ylanc how	. [10a. State 10b. County	,	10c. City, 7	Town or Lo	cation				10d. Inside City Limits
	e Ma 3e-f s	Director	Maryland Ceci	1	E1k	ton					1 X Yes 2 □ No
	ith th or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	
	s 23e gust		433 Melbourne	Boulevard 12. Was Decedent	Fuer in 11 C	12.1	21921	innania Origin? /S	nooffy Voc or No	United	States American Indian,
	ter de Item Inerr	Funeral	 Marital Status Never Married 2 Ma 	Armed Forces?		13.	Was Decedent of H f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, V	White, etc.
936	urs af	by	3 ₩ Widowed 4 Divorce	If Yes Give A			1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
Š	hin 72 hours after death with the Maryland b. Medisal Examiner must be notified at	Completed	15. Decede	nt's Education est grade completed)		16a. Deced	dent's Usual Occupa	ation during most of wor	kina	16b. Kind of Busin	ess/Industry
Maryland 21215-0036	E	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired)		T., II	O II
2	T		17. Father's Name (First, Middle	(act)		Ног	nemaker	18 Mother's Nan	ne /First Middle	Maiden Surname)	Own Home
and	be d d	Be c	Edward Conrac						Conrad	,	
2	2 should and Men is marke eumatic	၉	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street			r, City or Town, Sta	te, Zip Code)
	od 2 Ith a 27 is		Rosalie L. Par	k/Daughter		433 1	Melbourne	Bouleva	rd, Elkt	on, Maryl	land 21921
Je,	ges 1 and 3 t of Health If item 27 of other tr		20a. Method of Disposition	5 TD	20b. Plac	ce of Dispo	sition (Name of natory or other place	θ) Δ11011	Date St 19,	20c. Location - City	y or Town, State
E	nit. Pages lartment of tortent: If its injury of o		1 Ma Burial 2 ☐ Cremation , `4 ☐ Donation 5 ☐ Other (Cher	ry H	majory or other place ill Cemeter	y 20		Cherry Hi	11, Maryland
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service	Licensee	(40	H:	Name and Address icks Home 03 W. Sto	for Funckton St	erals. P	.A.	ryland 21921
			23a. Part1. Enter the disease, of shock or heart failure. Lis	r complications that caused t only one cause on each li	d the death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	v2	elimo-	mia					Onset and Death
	/Medical		resulting in death)	Due to (or as			. 1 i	. 1			
П	Examiner		S quentially list conditions.	b. Due to (or as	inely	two	è mee	Noc_			
	ed nsit	ulne	S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce or):	Lie				
	ificate be executed g physician and as the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):		: 0			
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-	* O 6	fedical									
Вох	eath certif attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,		23d. Date o Month	f delivery Day Year
	e dea the at	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 █No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown	t time of dea	th 5 ☐	Other (specify)			Worth	ouy rou
P.0	res that the de igned by the a be detached t	F.	Part II. Other significant condit	ions contributing to death t	out not resulti	ina in the u	nderiving cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
of Vital Records,	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Completed by	lix. Coc	non of	Colon	L	, , , ,		1 □ Y	es 200 No 3[☐ Probably 4 ☐ Unknown
Ö	w require been signature	iete		Ü					24a. Was		re autopsy findings available
Re	he la e has age 2	duic							autop	rmed2 dear	r to completion of cause of th? Yes 2 □ No
tal		O	25. Was case referred to medic	al				26. Place of Dea	1 ☐ Yes ath (Check only o		165 20140
Ž	Physicien: The law this certificate has t ral director, page 2 s	To B	examiner?	Hospital: 1 ☐ Inpati	ent 2 EF	R/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	lome 5 Resid	ience 6 🗆 Other ((Specify)
0 0	ng Ph fter th neral		27. Manner of Death	28a. Date of Inju	ury 2 ay Year) 2	8b. Time o Injury	Wor	k?	28d. Describe h	now injury occurred	
sio	tendi leath. tor: A the fu	catl		tigation			-	Yes 2 □ No	205 Leasting /6	Street and Number	or Rural Route Number,
Division	il or Attendi after death. I Director: A d in by the fu	Certification;		mined 289. Flace of III	tc. (Specify)	ie, farm, sti	reet, factory, office		City or Tow		or nurar noute ryumber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certify (Check only 2 Medice	ing Physician: To the best I Exeminer: On the basis of and manner si	of examinatio	edge, deat n and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the our	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	Fo the	Me	29b. Signature and title of certif				29c. Licens	e number		29d. Date signed (A	
			I Ani Ell	War MID			00	4823		8/17/	2005
	3		30. Name and address of perso	who completed cause of	death (Item 2	23a) (Type,	Print)	mais 8	7, 8	1160 1	1221921
	Sta Regist		31. Date filed (Month, Day, Yea		rar's Signatu	re .	neski				

State of Maryland / Department of Health and Mental Hygie 2 0 5 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT H. LEAF AUGUST 2005 9:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 7. Age (In yrs. last birthday) | | ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1**X**M 2□F Director Yrs. 213-26-7925 76 MAY 24, 1929 MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits itam 27 is markad other than "natural", or itams 23e or 28e-f show othar traumetic avant, it a Madical Examinar must be notified at Completed by Funeral Director 1 Yes 2 No QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 HARBOR DRIVE 21619 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1951 Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: 3 Widowed 4 Divorced 1957 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 MASTER CARPENTER COMMERCIAL 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tam 27 is markad oth 18. Mother's Name (First, Middle, Maiden Sumame) Be LARS TORSTEN LEAF ANNA KNIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a. nt: If itam 27 is. ISABEL LEAF/WIFE 1811 HARBOR DRIVE, CHESTER, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 08/05/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Sharrox 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician wastran /Medical Due to ur as a consequence of): Examiner Sequentially list conditions, if any, leading to initioulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 20 No 3 Probably 4 Unknown Completed Antlenges aronic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Delydration 1 ☐ Yes 2 ☐ No 1 ☐ Yes PXNO or Attending Physician: 25. Was case referred t adical Be 26. Place of Death (Check only one) examiner' Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 0 1 🗌 Yes this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. 2 Accident investigation 1 Yes 2 No Diractor: in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. I am and address of per or who co opleted cause of deal litem ype, Print) 2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005

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			1 - Stata Registrar		Ce	rtificate of	Death		Rag. N	L 0 0 0	2,000
	Physic	an	1. Decedent's Name (First, Middle, L	-				2. Date of D	Death	ay Year	3. Time of Death
	/Medi	al	Wali	Minay	ar			Aug.	. 7,	2005	12:30p ^M
	Examir	er	4a. Facility Name (If not institution, gi Shady Grove H	ospital		Rockvil			N	ic. County of Death	ery
ŀ	Funeral Director		215-13-0072	Sex 7. Age (In y. 1	rs. last birthday, Yrs.	Months Days		8. Date of B (Month, 2)	Birth Day, Yea 191	9. Birth Cou 7 Afgh	place <i>(State or Foreigi</i> ntry) anistan
	tand tow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
	he Mary 8a-f eh	ector	Md. Montgo	nery Ga	aither			·	,		1 ☐ Yes 2 🕵 No
	ath with the 23a or 2	rai Dire	10e. Street and Number 52 Anna Court			10f. Zip Code 20877				Citizen of What Cou ghanista	•
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example or must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗷 No	Hispanic Origin? (S lan, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	lo-	14. Race - Ameri Black, White, Specify: AS	etc.
15-0	72 h	ietec	15. Decedent's E (Specify only highest g	ducation a <i>de completed)</i>	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of world)	king	16b.	Kind of Business/Ir	dustry
121	within ene. then	дшс	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +	1	DO NOT use retire	nd)			none	
<u>d</u> 2	Hiled Hygi other	e Cc	17. Father's Name (First, Middle, Las	·)		<i>y</i>	18. Mother's Nan	ne (First, Middl			
/lan	uld be Menta Irked Itic ev	To Be	Ali Minayar				Smbol	Mina	yar		
Maryland	2 sho and h Is me		19a. Informant's Name/Relationship							or Town, State, Zip	
	1 and Health In 27		Alia Minayar 20a. Method of Disposition		52 Z	Anna Cou	urt Gait	hersb		, Md. 20	
Baltimore,	Pages ment of Hant: If its		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State Ge	cemetery, cre orge \	matory or other pla Washingt	ton 8/10	/2005	Ade	Location - City or To Elphi, M	id.
Ball	permit Depert import any in		21. Sign ture Funeral Service Vice	art of	4 42	2. Name and Addre	edy St.,	N.W.	Wash	fortuary nington,	DC 20011
	Physician /Medical		23a. Part1. Enter the prease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused the de one cause on each line. Pneumoni Due to (or as a cons	.a	ter the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death hours
L	Examiner		Sequentially list conditions,	Sepsis w		eptic sh	nock				hours
	cuted	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	shock li	. ,						hours
68760,	eath certificate be executed attending physician and for use as the burial-transit	/Medical Examiner	resulting in death) Last	Due to (or as a cons	-	ailure					hours
89	tificat ng phy as the	ledic		0.							
.O. Box	that the death cer ed by the attendin detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	у			23d. Date of delive Month	ery Day Year
rds, P.	es be	þ	Part II. Other significant conditions Parkinsons	contributing to death but not r	esulting in the u	nderlying cause giv	ren in Part I.			use contribute to the	ne cause of death?
Records,	sician: The law requir certificate hes been si irector, page 2 should	Completed	General debi	lity				24a. Was auto perf		24b. Were auto prior to co- death?	psy findings available mpletion of cause of
Vital	an: T	0	25. Was case referred to medical				26. Place of Dea	1 Yes	2.X N	o 1 ☐ Yes	2 No
Ţ	A P	ToB	examiner? 1 ☐ Yes 2 💆 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	ar			6 ☐Other (Specif	y)
ion of	After Aune		27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at	28d. Describe			,
Division	al or Attendes safter death	Certification	3 Suicide 6 Could not be determined		home, farm, str	reet, factory, office		28f. Location City or To	(Street a own, Stat	nd Number or Rura e)	l Route Number,
	To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by	Medicai (29a. Certifier (Check only one) 1 Certifying Plant Certi	nysician: To the best of my k ninar: On the basis of exami and manner stated.	nowledge, death nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the	cause(s	s) and manner as si ad place, and due to	ated. the cause(s)
	To the within To the Comp	Ň	29b. Signature and title of certifier	V(,	29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)
(2) ouma	Khane	yn	D005	8965		Aug	ust 7,	2005
1	20		30. Name and address of person who								-
	Sta	e.	Saima Khawaja	11119 Rock 32. Rediatrar's Si	ville hature	Pike, S	uite 10	0 Rock	vil	le, Md.	20852
	Registr	_	AUG 1 2 2005	were to by							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles Aug. 9, 2005 6:15 p Maude /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6724 Oakland Avenue Riverdale Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2 □ F Director 579-40-2466 Nov. 20, 1931 Missouri 73 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow treumatic evant, the Medical Examiner must be notified at 1⊠Yes 2 No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6724 Oakland Avenue Itams 23s 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after ☐Yes 2☐No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates: 1952-54 þ 3 ☐ Widowed 4 ☒ Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Roofer/Tinner Home Improvement permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse N. Maude Myrtle Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Maude - Son 14415 Cuba Road, Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 08/11/2005 Alexandria, Virginia ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Euneral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD allane/ lan 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIL NOW SMALL CELL LUNG LANCED 3 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 ician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the the Physi 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ØYes 2 □ No 3 □ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed2 1 Ves 2 No To the Hospitel or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

State

LAURDICEP.S. HHARSPA 7247 Hanova 2. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 1 2005

29c. License number

D 20680

Parkway 16, conbelt

29d. Date signed (Month, Day, Year)

MD 20770

105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie e 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:00 P AUDREY JUNE MASTERS AUG. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LORIEN REHAB CENTER COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 XF Director 189-24-5036 87 JUNE 2, 1918 OHIO Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f ehow Examiner must be notified at Director 1 ☐ Yes 2 No MARYLAND HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itams 23a 6334 CEDAR LANE Funeral 21044 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Innportant: if tiem 27 is marked other than "natural", or Itan any injury or other traumatic event, the Medical Feed Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PAUL HOLSTEIN CLARA WHERRIT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA TRUEMPER-FRIEND 4400 MANOR LANE, ELLICOTT CITY, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) NATIONAL MEMORIAL PARK 8/11/05 FALLS CHURCH, VIRGINIA Euneral Sen 22. Name and Address of Facility NATIONAL FUNERAL HOME 7482 LEE HIGHWAY, FALLS CHURCH, VA 22042 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. 23a. Part1. Enter the disease, or composhock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** SEVERE PULMONARY VASCULAR DISEASE MONTHS resulting in death) /Medical Due to (or as a consequence of). **Examiner** CARDIOVASCULAR ACCIDENT MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):

Division of Vital Records, P.O. Box 68760,

6	contributing to death but not resulting in the unde	erlying cause given in Part I.	1 Yes 2	ise contribute to the cause of death? □ No 3 □ Probably 4 ※Unknov
			-	
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	Hospital: 1 Inpatient 2 ER/Outpatient	Other	th (Check only one)	6 □Other (Specify)
	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not l 4 Homicide determined		t, factory, office	28l. Location (Street and City or Town, State)	d Number or Rural Route Number,)
29a. Certifier 1 X Certifying P	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occu	and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier	_	29c. License number	29d. Date	e signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registra

SHAKUNMALA GUPTA, MD 9650 SANTIAGO RD. COLUMBIA, MD 21045

can & specie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 1 1 2005

State of Maryland / Department of Health and Mental Hygiege 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Chester Roy McFarland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** erlana If Under 24 Hrs. Acrea sital HEART GAN 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Hours Days Min 1**X**1M 2□ F 75 Yrs. Pennsylvania Director 189-22-5272 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b County 10d. Inside City Limits s 23a or 28a-f show Completed by Funeral Director 1 ☐ Yes 2 🛣 No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12579 National Pike 21536 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Examine to filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced natural White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Self-Employed Retail/Fruit Market 12 should be filed w and Mental Hygier is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl McFarland Elizabeth Hopwood 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 f Health item 27 i Shirley L. McFarland/Wife 12579 National Pike, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 🙀 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important: If any injury or once. `4 Donation 5 Other (Specify) Hopwood Cemetery Aug. 16,2005 Hopwood, PA 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, erma P.O. Box 275, Grantsville, MD 23a. Part1. Extenthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician ACUTE RENAL FAILURE disease or condition resulting in death) FIVE DAYS /Medical Due to (or as a consequence of): Examiner UROSEPSIS FIVE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jording Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.0. detached Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 21**X**No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one. examiner' Other: 1 ☐ Yes 2 🗙 No Certification: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) De D33417 (MARTLAM) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES M. MOEN. MD 1068 NATIONAL HILHWAY LAVALE, MARYLAND 31. Date filed (Month Pay, Year) AUG 15 32. Registrar's Signature 2005 Space Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mayhew 23 57PM August 2005 12 /Medical 4c. County of Death Baltimore City 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** onus Ho 1405 John Year If Under 24 Hrs. Ja. Date of Birth (Month, Day, Year)
July 16 2002 5. Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign Country) Months Days Hours Min 1**X** M 2 □ F 3 212-65-2765 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits El Paso Fort Carson , Colorado Springs co. XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5517 F Aachen Drive 80913 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② TNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Specify: white 1 ☐ Yes > No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) never worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Travis Mayhew ပ Sarah Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 F Aachen Drive, Fort Carson, CO. Travis Mayhew /father 80913 08/17/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Westernport, Maryland Philos Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 7- W agre 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days Pulmonary hemorrhage Due to (or as a considence of): ERTIFIC TION APPROVE BY MEDICAL EXAMINER of Grein body (hot dog) Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown neumothorny 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner**

burial-transit

the

attending physician

ed by the detached

should be

filled in by the funeral director,

within 24 hours after death. To the Funeral Director: After

signed

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

permit. Page Department of Important: If any injury or once.

Funeral

Director

28e-f show

0

or Items 23a

"natural',

and Mental Hygiene. Is marked other then

traumatic event, the Madical

Exeminer must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical Be ۴

Certification:

Medical

State

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Thomicide

1XYes 2□No

29a. Certifier

5 Pending investigation 6 Could not be determined

RESIDENCE

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 7/11/05

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 11:005

28c. Injury at Work? 1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred SUBTECT

CHOKED ON TOOD

28f. Location (Street and Number or Rural Route Number, City or Town, State) 25507 OIDTO WHE ROSE, OLDTOWN, HO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

RES- 000

29c. License number

29d. Date signed (Month, Day, Year) August 13, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Knister Nelson, MD North Wolfe 600 31. Date filed (Month, Day Year) Registrar's Signature 8 2005

Baltimore MD

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2e 0 0 5 27901 Certificate of Death

	Discolati		1. Decedent's Name (First, Middle, Las	st)					2	. Date of Deat Month	th Day	Year	3. Time o	of Death
	Physici /Medic		John Jarlath Murp	ohy						August			7:30	рм
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of			_	County of Deat	1	
	Ladiiiii		Holy Cross Hospit	al			Silver	Sprine	α		м	ontgome	rv	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last	birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth			nplace (State untry)	or Foreign
	Director		578-42-3515	X M 2□F	78	Yrs.	Months Days	Hours	Min.	(Month, Day, ept. 9			untry) eland	
			Usual Residence of Decedent							cpc. J	, 10	20 1 110	Land	
	ylany Now		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside (City Limits
	Mar	ţō	Maryland Montgo	merv	Rock	vill	e						1 ☐ Ye	s 2 No
	128e	rec	10e. Street and Number	J			10f. Zip Code			1	0g. Citiz	en of What Co	untry?	
	3a o		14002 Drake Driv	e			20853	3			US	27		
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then *neturel', or Items 23a or 23e-f show event. Ite Midfred Examinar must be mailted at	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Was Decedent of H		gin? (Specif	fy Yes or No-		4. Race - Ame		
_	r lter	듄	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 □ N	10	í			, Puerto Rio	can, etc.)		Black, White	ite	
3	ol', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII		I□Yes 2☐No	Specify:			5	Specify: WII	rce	
0500-c	2 ho	Completed	15. Decedent's Ed		10	6a. Deced	lent's Usual Occup	ation			16b. Kin	d of Business/	ndustry	
2	n n	pie	(Specify only highest gra	College (1-4or 5	:41	life. L	kind of work done OO NOT use retired	auring most d)	of working					
7	y with	Eo	8	College (1-401 5	· · ·	Fi:	re Fighte	er			Fede	ral Go	vernme	nt
0	Hyg othe ent,	0	17. Father's Name (First, Middle, Last)		·		3		r's Name (/	First, Middle, M			verme.	
and	d be enta ked ked	ToB	Thomas Murphy					Win	ifred	Ronay	ne			
2	12 should be filed within and Mental Hygiene. T is marked other then "reumatic event, Ite Mas	-	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailin	g Address (Street			-		Town, State, 2	ip Code)	
<u> </u>	d 2 sith ar		Catherine Murphy	v/ Wife		1400:	2 Drake D	riva	Pock	i110	Maa	backs.	00E2	
a)	is 1 and 2 should of Health and Men item 27 is marke other treumatic.		20a. Method of Disposition	,,	20b. Place	of Dispo	sition (Name of		Dat	0		ation - City or		
<u></u>	0 = 5		1 Burial 2 □ Cremation 3 □				natory or other place even Cemete		-	st 12				
ранито	permit. Pag Department Importent: any injury once.		'4 □Donation 5 □ Other (Specifical Services Licer	··					200	100	ilve	r Sprin	ng, Mai	ryland
N N	Depa mpo nny ir		21. Signature of Funeral Service Licer	1588		Fi	Name and Addre rancis J. OO Univer	S COII	ins F	uneral	Hom	e Inc.		20022
_	402 s d		y you	scereo								spring		
			23a. Part1. Enter the lisease, or m shock, or heart failure. Le only	plications that caused one cause on each lir	the death. D	o not ent	er the mode of dyir	ng, such as o	cardiac or r	respiratory arre	est,		Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition	a IDIOPA	THIC	P	LMONAR	Y FI	BROS	IS			YEAR	
	/Medical		resulting in death)	Due to (or as										
	Examiner			D. PNEU	MONIA								DAYS	
	-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as										
	uted d ansit	Ē	that initiated events	ATRIA	L F	IBRI	LLATION						DAYS	
,	be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequenc	ce of):								
٥	e be rsicia e bur			d.										
09/89	death certificate be executed e attending physician and d for use as the burial-transit	ian/Medicai												
gox	cert nding use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23	3d. Date of deli	very	
ă	atte atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at]Ectopic pregnancy] Other (s <i>pecify)</i>	/				Month	Day	Year
j.	the c y the	Physi	9 Unknown	9□ Unknown										
7	w requires that the de been signed by the should be detached	/ P	Part II. Other significant conditions of	contributing to death b	ut not resultin	g in the ur	nderlying cause giv	en in Part I.		23e. Did tob	oacco us	e contribute to	the cause of	death?
SD	sign d be	d by								1 □ Ye	es 2 🗆	No 3□Pro	bably 4 🔀	Unknown
ecords	requ	ompieted								0.4 . 146				
ē	has b	npi								24a. Was a autops perform	v	24b. Were au prior to death?	ompletion of	cause of
<u>r</u>	The l	Co								1 Yes 2		1 🗆 Yes	2 № No	_
Vital	Physicien: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?						of Death (Check only on	e)			
0	nysic nis ce	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpatie		Outpatien	t 3□ DOA Oth	ier: 4 □ Nur	rsing Home	5 🗆 Reside	nce 6	□Other (Spec	rify)	
	iding Physicien: th. After this certifica funeral director, p		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry Year) 281	b. Time of Injury	28c. Injur Wor	y at k?	28	d. Describe ho	w injury	occurred		
Sion	el or Attending F safter death. I Director: After d in by the funer.	ertification:	2 ☐ Accident investigation	n				Yes 2□N	No					
<u> </u>	l or Attendatter deatl Director:	ific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju- building, etc	ury - At home	, farm, str	eet, factory, office		28	f. Location (St. City or Town		Number or Ru	ral Route Nui	nber,
<u>></u>	spitel or ours afte lerel Dir filled in	Sert	4 Homicos	building, etc	o. (Specify)					ony or roun	, olalo,			
	To the Hospitel or within 24 hours aff To the Funerel Discompletely filled it	aic		nysician: To the best										
	e Hos 24 hos e Fun detely	edicai	(Check only 2 Medical Exar	niner: On the basis of and manner sta		and/or inv	estigation, in my o	ppinion, deat	h occurred	at the time, da	ate and p	place, and due	to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier		Ad-		29c. Licens	e number		2	9d. Date	signed (Month	, Day, Year)	
			D. Vilwam	adily 12	In home	2	D 43	464			4060	ST-09-	2005	
7	15 41		30. Name and address of person who	completed cause of d	eath (Item 22	a) (Tune	Print)							
	•		VILLEAM ADITYA - D. RE					E 204	20	KVILLE	, N	0 - 2080	2	
	CA			3€ . Registra	ar's Signature	-)		/	- 50		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 11 20	05 Registra	, B.	200	and the same							
	5.01			The same of the same of	_									

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 26 15

			1 - For State Registrar	otato oi mai	Ce	rtificate of l	Death		g. No.	J 6	-1306
	Physici	an	Decedent's Name (First, Middle, L Emma	ast) B. Mun				2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	August 4,	2005 4c. County	of Death	6 AM M
	Exami		Prince George's Hos	pital Center		Cheve			Prince		æ's
	Funeral Director				In yrs. last birthday 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpi Coun	lace (State or Foreign
	ס		Usual Residence of Decedent					January 1	9, 1944	South	Carolina
	daryla f show	ō	10a. State 10b. County D.C.	1	IOc. City, Town or L		ningtan			10	0d. Inside City Limits 1 Yes 2 No
	or 28e-	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	/hat Coun	
	s 23a onust b		4319 Brooks Stree				20019		U.S.A.		
920	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "naturel', or Items 23e or 28e-f show event. I'm Medical Exain and mast les routified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		America k, White, e	etc.
- - -	n 72 h	ietec	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usual Occupa a kind of work done of DO NOT use retired	ation during most of work	ing 1	6b. Kind of Bu	siness/Ind	ustry
212	filed withi Hygiene. Other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	H	busevife	,		DOm	estic	
yland 21215-0036	should be file nd Mental Hy marked oth marked ovent	To Be (17. Father's Name (First, Middle, Las Devid	Wright			18. Mother's Name	e (First, Middle, Marah L. To		9)	
, mary	d 2 sth ar		Mr. William M. Munn		4319	ing Address (Street a Brooks Street					Code)
Baltimore,	Pages 1 an ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ 1 □ Ponation 5 □ Other (Special Control of Control o		20b. Place of Dispo cemetery, cre Resurrect	osition (Name of matory or other place ion Cemeters	e)	t 9, 2005	Oc. Location - (Clinton	-	
Balt	permit. Page Department of Important: If any injury or once.		21. Sunatule of Funeral Service Lice	hadees	4	2. Name and Addres 339 Hunt Pla	s of Facility Ro	llins Fune Shington, I	al Home.		
ı.	Physician		23a. Part1. Enter the disease, or construct, or heart failure. List on Immediate Cause (Final disease or condition	4	e death. Do not en	ter the mode of dying					Approximate Interval Between Onset and Death
•	/Medical Examiner		resulting in death)		consequence of):	-4	1 VORC			-	2042
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	onsequence of):	1c 51	hock				days
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a bete	3					4 edis
08/0N,	eath certificate be executed attending physician and for use as the buriat-transit	Medical E		Due to (or as a d		usion					46415
×	certific Iding p		IF FEMALE:	23c. If yes, outcome of	pregnancy				001.5		/
.c. Bo	00	hysician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 (4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			Mon	of deliver th [y Day Year
ras, r	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause give	n in Part I.			oute to the	a cause of death?
S L	e la has ie 2	ompleted						24a. Was an autopsy performe 1 Ves 20	pr ed? de	or to comeath?	sy findings available pletion of cause of
		BeC	25. Was case referred to medical examiner?				26. Place of Death		2100		Warner Comments
5	S 0 0	. To	1 Yes 2 No 27. Manner of Death	Hospital: Malinpatient 28a. Date of Injury	2 ER/Outpatier		4 U Nursing Hor	ne 5 Residen			
000	ath. r: Afte	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yo	ear) Injury	Work	? 'es 2 □ No	edd. Describe now	injury occurre	u	
DIVISION	tel or Atte s after de el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		- At home, farm, str Specify)	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number State)	or Rural	Route Number,
	To the Hospitel or Attending Phymin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying P	hysicien: To the best of n miner: On the basis of ex and manner stated	amination and/or in	n occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	and due to the cau ed at the time, date	se(s) and man and place, ar	ner as sta id due to t	ted. the cause(s)
	Yot with Tot	2	29b. Signature and title of certifier	ala.	MD	29c. License			Date signed		ay, Year)
	LA P		30. Name a address of person who	.1 /	h (Item 23a) (Type,	Print) George	is	Cham	1 10		
	Sta	e.	James H 31. Date filed (Month, Day, Year)	32. Registrar's	Frince Signature	George 1	respetal	LAPDE	014.00	D	
	Registr		AUG 1 2 2005	But a land	Moser						

RKD

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		Stata Registrar			Certificate of	of Death	1	Reg. No.		T
nysicia		1. Decedent's Name (First, Middle, I			Wa = = a = a = a		2. Date of D Month	Day	Year	3. Time of Death
Medic	al .	Linda	J.	·	Messerscl	m, or Location of De	AUGUS'		005 ty of Death	12:15P.
xamin	6	4a. Facility Name (If not institution, g				NNAPOLIS	ea(r)		ARUNI	
neral		1056 EAGLEWOOD DE 5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last b	irthday) If Under 1 Y	ear If Under 24 h	rs. 8. Date of Bi	irth	9. Birthi	place (State or Forei
ector		220-56-9164	1 □ M 2 🛣 F	54	Yrs. Months Da	ays Hours M	in. (Month, D Aug. 1	13,1950	Mar	yland
		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	wn or Location					10d. Inside City Limit
	ō	MD Anne A	runde1		apolis					1 ☐ Yes 2 🔯 N
	rect	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of	What Cou	ntry?
event, the medical Examiner of the centuries at	ie D	1056 Eaglewood	Road, Apt.	TD	2	1403		US	SA	
	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XX0ivorced	If Yes, Give	1	13. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nuerto Rican, etc.)	o- 14. Ra Bl	ace - Ameri ack, White, ify: Wh	
	Completed	15. Decedent's (Specify only highest of	Education		a. Decedent's Usual O	ccupation	workina	16b. Kind of	Business/In	ndustry
	npie	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of work di life. DO NOT use re	atired)				
		17, Father's Name (First, Middle, La	4	A:	rt Teacher	10 Matheda I	Name (First, Middle		ation	1
	Be c						, ,	s, Malueri Suma	mie/	
	ဥ	Frederick H. F		19	b. Mailing Address (St	-	rie Ward	ber. City or Town	n. State. Zir	Code)
		Carol Lee Fogl			5417 Smoot					,
1		20a. Method of Disposition	- 50	20b. Place	of Disposition (Name of ery, crematory or other	of	Date	20c. Location		
		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			crest Cemet		11-2005	Annapo	lis.	MD
ġ		21. Signature of Funeral Sorvice Liv	A.69		22. Name and A	ddress of Facility		•		1110
OUC		1.6	A		12 Ridg	y Funera gely Aveni	ue, Annap	olis, M	D 214	01
ě		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	d the death. Do	not enter the mode of	dying, such as card	diac or respiratory	arrest,		Approximate Interval Between
n al er		Immediate Cause (Final disease or condition resulting in death)	a. Market Due to (or as	a consequence	One CSP	DIOVASO	icon p	DISCON	2	Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	a of):					
	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):					
		(·	•					
	edicai		d							
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	th 3 Ectopic pregn 5 Other (specifi				ate of deliversionth	ery Day Year
		Part II. Other significant conditions	contributing to death b	out not resulting	in the underlying cause	e given in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
	d by						_ 10	Yes 2 No	3 Prob	oably 4 Unknow
	Completed						24a. Was		. Were auto	opsy findings availal
	E o		-				— auto perf 1 ☐ Yes	ormed? 2 \(\text{No} \)	prior to co death?	mpletion of cause of 2 No
	a l	25. Was case referred to medical				26. Place of I	Death (Check only			2010
	ToB	examiner?	Hospital: 1 Inpatie	ent 2 ER/C	Outpatient 3 DOA	Other: 4 Nursin	g Home 5 ☐ Res	idence 6 📆	ther (Specif	y) SCENE
		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	iry 28b	Time of 28c.	Injury at Work?	28d. Describe	how injury occu	irred	
	atic	2 ☐ Accident investigat	ion			1 ☐ Yes 2 ☐ No				
	Certification:	3 Suicide 6 Could not determine	building, et	tc. (Specify)	farm, street, factory, of		City or To	wn, State)		al Route Number,
	edical		Physician: To the best aminer: On the basis o and manner st	f examination a						
	Me	29b. Signature and title of certifier			29c. Li	cense number		29d. Date sign	ed (Month,	Day, Year)
		▶ Mayore	meck	ele im	0.	C.M.E.		AUGUST (5, 200)5
		30. Name and address of person whe MARYPMW	no completed cause of d	u		N STREET,	BALTIMOR	E MARYL	AND 21	L201
			22 5-4	rar's Signature						
Sta gistr		31. Date filed (Month, Day, Year)	0 2005 32. He	rar s Signature	4 Specie					

State of Maryland / Department of Health and Mental Hygien 1 1 - State Amend Item 24a 28b per me G846 8-24-05 tas

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Auq ^D2005 Year DANIEL MERSON 4, T.ON 12:35 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Univ. Of Maryland Medical Syst Baltimore If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 🔀 M 2 🗆 F 40 Director 220-92-3873 May 18, 1965 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked othar than "natural", or itams 23a or 28a-f shov traumatic evant, the Medical Evaninst must be notified at Director 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11902 Sun Valley Drive Funerai 21742 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. nours after 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) Hardwood Floor Specialist Interior Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F is marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked c any injury or other traumatic eve 2008. Paul Merson 2 Louise Seals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Tenley / Fiance 11902 Sun Valley Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of August 9, 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens! Frederick, Maryland 21. Signature of Europa Service Lice 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwv. Frederick, MD 21701 9501 Catoctin Mtn. Hwy, Frederick, MD 23a. Part1. Enter the disease or comshock, of beart failure List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between CENTERCATION APPROVED BY MEDICAL EXAMINER Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Closed Head Injury /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 X Yes 1 ☐ Yes 2 ☐ No 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
XX Yes 2 No Hospital: XXI Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1928 Certification; 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending after death. X Accident 3 Suicide 7/30/05 investigation 20.00 1 ☐ Yes 2√ No Motorcycle Collision 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 901 Baltimore in by New Market, Md 4 \ Homicide Street within 24 hours a To tha Funaral [1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16540 Aug 10, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tawil, MD 22 Greene Street, Baltimore, Maryland 21201 Isaac 31. Date filed (Month Pay, Year) 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)				1 = For State Registrar	Otato or m	arytaria /	Certific			Re	eg. No.	00	2150
Betty Louella Nortis 4 Facily Name Price Mades you pussed and managed 4 Facily Name Price Mades you pussed and managed 4 Facily Name Price Name 4 Facily Name Price Name 4 Facily Name Price Name 4 Facily Name Price Name 4 Facily Name Price Name 5 Sec Name Price Name 7	J.	Physici	ian	1. Decedent's Name (First, Middle, La	st)							Year	
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Private Priv	j			4a. Facility Name (If not institution, giv	e street and number)		4b. C	City, Town, or	Location of Dea	ıth	4c. County	of Death	
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P.O. Box 270, Leonardtown, Maryland 20650	2	d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle, M	faiden Suman	ne)	
P.O. Box 270, Leonardtown, Maryland 20650	2	Men Men arke	ပို	Ralph Raymond Clark					Daisy Mc	Clorke Hayn	es		
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P.O. Box 270, Leonardtown, Maryland 20650	<u> </u>	and lealth m 27					+5258 Co1	ledoral1	Court, C				
P.O. Box 270, Leonardtown, Maryland 20650	5	or ot			Removal from State	20b. Place o	of Disposition (ery, crematory	Name of or other place	9) Δ11		20c. Location -	City or To	wn, State
P.O. Box 270, Leonardtown, Maryland 20650		men men tant: jury		4 ☐ Donation 5 ☐ Other (Specify	r) =	Windy (Cove Ceme	etery		•	ath Coun	ty, Vi	r_inia
P.O. Box 270, Leonardtown, Maryland 20650	<u> </u>	ermit epart npor ny in		21. Signature of Funeral Service Licer	isee U	89-	22. Name Mattir	and Addres	s of Facility	neral Home	РΔ		
Physician //Medical Examiner The sequencially list conditions of the sequence	_	0 □ = 0		Muchael X.	Jarden	el .	P.O. E	30x 2/0,	Leonardt	own, Maryla	nd 20650		
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Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying lease or injury resulting in death) Last Due to (or as a consequence of):				disease or condition	, Met	astat	ic J	mali	Cell	Cuna (ANCE	2	Onset and Death
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The past 12 months of the past 12 months? If FEMALE: 23c. If yes, outcome of pregnancy 1	(§#)	-Adminit	_	Sequentially list conditions,									
The past 12 months of the past 12 months? If FEMALE: 23c. If yes, outcome of pregnancy 1		ed sit	lne	cause. Enter Underlying	Due to (or as	a consequence	of):						
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Second of the completion of cause of death? 23d. Date of delivery 23d. Date of D	2	be eg icien buria			200 10 (01 43	a consequence	01).						
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Cross, M.D. 25500 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	5 :	th.	tlor			Year)	Injury			200. 0000100 1100	a injury occurr	00	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Cross, M.D. 25500 Point Lookout Road, Leonardtown, Maryland 20650 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	:	withir To th comp	ž	29b. Signature and tyle of certifier				29c. License	number	29	d. Date signed	(Month, D	Pey, Year)
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State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	7 "			Patrick Cross, M.I				Road.	Leonardt	lown. Mars	land 2	0650	
		Sta	te	31. Date filed (Month, Day, Year)			4			11CLL y		5550	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 4 Day 2005 Year **Physician** 9:30a William D. McKoin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. | 1912 5. Social Security Number 6. Sex 1 AM 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 284-09-5679 Missouri Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or itams 23a or 28a-f show 10d. inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.

ant: If item 27 is marked other then "natural", or items 23a or 28a-1 ehow ury accepted the most be natified at 1X Yes 2 □ No Funeral Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3284 Gleneagles Drive United States 12. Was Decedent Ever in U.S. Amed Forces?

1 A Yes 2 No 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 1945 American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William D. McKoin Emma Smith 19a. Informant's Name/Relationship (Type, Print) Moneva C. McKoin/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3284 Gleneagles Dr., Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Norbeck Memorial Park 08/10/2005 1 \ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury pu Olney, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
McGuire Funeral Service, Inc.
7400 Georgia Avenue, N.W. Wash., D.C. 20012 once. Thompson re 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 days Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Dissass or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 卷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2**₹**□ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? After! Medical Certification: 28b. Time of 28d. Describe how injury occurred Injury 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) louns August 4, 2005 W D0061856 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Phillip Dr. Olney, MD Heather Lorenzo
31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 10

2005

			1 - State Registrar 1. Decedent's Name (First, Middle, Las	State of Marylan	d / Depa	artment of He tificate of D	ealth and I Death		g. No.	
	Physic /Medi		JOSEPH	MORRIS				Month AUG. 5	Day Yea	3. Time of Death 1:25 PM
	Examir Funeral	ner	4a. Facility Name (If not institution, give CORSICA HILLS NUR 5. Social Security Number 6. Social Security Number	SING HOME 7. Age (In yrs.		4b. City, Town, or I CENTREV If Under 1 Year Months Days		8. Date of Birth	4c. County of De QUEEN A	
	Director		217–36–0796 Usual Residence of Decedent	85	Yrs.			JUNE 27	, 1920	MARÝLAND
	e Marylan la-f ehow	ctor	10a. State 10b. County QUEEN A		y, Town or Loc ENTREVI					10d. Inside City Limits 1 Tyes X No
	with th	Director	10e. Street and Number	- DOAD		10f. Zip Code			g. Citizen of What	Country?
36	d within 72 hours after death with the Maryland Jene. r then "natural", or items 23a or 28a-1 ehow the Medical Exantinat remail be notified at	by Funeral	3040 CHURCH HIL 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 XNo If Yes, Give	11	21617 Vas Decedent of His Yes, specify Cuban ☐ Yes 2 X No			14. Race - Ar Black, W	merican Indian, hite, etc. WHITE
Maryland 21215-0036	C * 69	Completed b	3	Year or Dates: ucation de completed) College (1-4or 5+)	16a. Deced	ent's Usual Occupat kind of work done du DO NOT use retired)	ion	king	6b. Kind of Busines	
121	filed within I Hygiene. other then		12 17. Father's Name (First, Middle, Last)	-0-	FAR	MER			FARMING	
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	s 1 and 2 should t f Heelth and Meni item 27 is marker other treumatic		19a. Informant's Name/Relationship (TEMILY D. MORRIS/	• •		g Address (Street ar				
Baltimore,			20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	emetery, crem	sition (Name of eatory or other place) EMORIAL P) !		Oc. Location - City of	
Balt	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	Bleff .	FE	Name and Address LLOWS, HE 8 S. LIBE	LFENBEIN	N & NEWNA	M FUNERAI	HOME, P.A.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death the cause on each line.	. Do not ente	er the mode of dying, Lecy Stt	such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions, if any, backing to firm ediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence)	res	dement	6			12 mas
68760,	tificate be executed ig physician and as the burial-transit	edicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a a c sequence)	uen e of):					3 days
	The law requires that the death certifical title hes been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 1	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ords, P	w requires that been signed b should be deta	ted by Pł	Part II. Other significant conditions co				in Part I.	23e. Did toba	~ .	to the cause of death? Probably 4 □Unknown
		Completed by	95 W	·		·			prior to	
<u> </u>	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	Othor		h <i>(Check only one)</i> me 5 Residen	ne 6 DOther (So	acity)
	ding After	ation; T	27. Manner of Death 13 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury a Work?		28d. Describe how		осиу)
DIVISION	= 00>	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, larm, stre	et, lactory, office		281. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospitel or All within 24 hours effer of Towne Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Decertifying Phy 2 Medicel Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the time, estigation, in my opin	date and place, tion, death occurr	and due to the cau red at the time, date	se(s) and manner a a and place, and du	is stated. e to the cause(s)
1	o T K T O	W	29b. Signature and title of fertifie	~ mo		29c. License n	1735	290	Date signed (Mon	oth, Day, Year)
4	MD)		30. Na and addre s of person who cor			rint)		00, CHEST	ERTOWN, M	D 21620
	Sta	_	31. Date filed (Month, Day, Year)	32 egistrar's Signati	ure					

Baltimor
68760,
Box
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P.O.
ords,

State of Maryland / Department of Health and Mental Hygie LeU U 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** GENEVIEVE MILDRED NICODEMUS 15, 2005 4c. County of I 2:45 am /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death of Death Examiner WASHINGTON BOONSBORO REEDERS MEMORIAL HOME 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 6, 1927 Funeral 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours 212-24-5543 Yrs. MARYLAND 78 Director Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner rust be notified at BOONSBORO 1 ☐ Yes 2 XNo WASHINGTON Director MARYLAND the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7448 SHARPSBURG PIKE 21713 U.S.A. or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married per mit. Pages 1 and 2 should be filed within 72 hours aff Desertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, ILB Musical Pages. 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMÁKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN CLAYTON MOSE EMMA GERTRUDE WALLIZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WELTY C. NICODEMUS, HUSBAND 7448 SHARPSBURG PIKE, BOONSBORO, MARYLAND 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 2 Cremation 3 Removal from State MIN. VIEW CEMETERY 8/19/2005 SHARPSBURG, MARYLAND 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of F 7606 OLD NATIONAL PIKE Paul M. Dean BAST FUNERAL HOME BOONSBORO, MARYLAND 23a. Part1. Enter the dise shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chvonic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): clan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ó Dav Year 4 Pregnant at time of death 5 Other (specify) the ; Physi þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Aunknown Completed Division of Vital Reco 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has rmed? 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hou. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of ray knowledge, bear occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) B0062223 30. Name and address of person who completed cause of Dr. Praveen Bolarum 340 Mills Street, Hagerstown, MD 21740 301-739-7100 AUG 16 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fh 8849 11-10-05 vt.
State of Maryland / Department of Health and Mental Hygiene 0 55

27909 Registrar Amend Item #5,76* Per FH G 848 10717,055 JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FLORENCE Month NORRIS Ι August 2005 10:41 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING 8. Date of Bin 1915. Birthplace (State or Foreign (Month, Day, Year)

JULY 8 1923

SOUTH CAROLES MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 F 90 82 Yrs Director Usual Residence of Decedent the Maryland 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be notilized at Directo 1 Ves 2 No DC WASHINGTON.DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 319 TODD PLACE N.E. 20002 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th PRINTING GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JASPER** IRBY 2 Leila Irby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an FLOYD HAYES/GODSON 10909 LAYTON ST. UPPER MARLBURG, MARYLAND 20774
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages I Department of H Importent: If ite any injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 8/14/05 Landover Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, sist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OSTEOMYELITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) certificate be executed burial-transit Cause (Disease or injury that initiated events Diabetic Ulcers resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 lan/Medical Cavitary Lung Lesion use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery requires that the death 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year Physici 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2₺ No 1 Yes 2X No 1 Yes the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther. 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Atter 1 X Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Funerel L 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0057630 Ule ,2005 the 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun M.D. 11000 Huntets View Ellicott City, Mary4and 21042 31. Date filed (Month, Day, Year) . Registrar's Signature AUG 1 2 2005 Registrar

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	Physic	ian	Decedent's Name (First, Middle, Last) Stephen Isaa	c Nic	holson			2. Date of Death Month	Day Yea	1 4 4
	/Medi		4a. Facility Name (If not institution, give s		11015011	4h City Town or	Location of Death	AUGUST	18, 2005 4c. County of De	5:45 P ^M
2	Examir Funeral Director	ier	PENTINSULA REGIONAL 5. Social Security Number 6. Sex	MEDICAL	(In yrs. last birthday)	SALIS If Under 1 Year Months Days		8. Date of Birth (Month, Day, 10/24/1	WICOMIO 9. B	CO CO irthplace (State or Foreign Country)
3			Usual Residence of Decedent					10/24/1	965 Ma	ryland
	how	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	8a-f	octo	Maryland Wicomico		Salisbury					1∑Yes 2 ☐ No
	th with the 23a or 2	Funeral Director	1708 Dover St.			10f. Zip Code 2180	04	10	og. Citizen of What USA	Country?
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	 Was Decedent Evaluation Armed Forces? 1 ☐ Yes 2 X Notes If Yes, Give Year or Dates:)	Was Decedent of Hi I Yes, specify Cuba I □ Yes 2☑ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, Wt	nerican Indian, lite, etc. White
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Maryland	12 should be and Mental	To Be	Mickey Roland Nich	olson			Esther 1			
Mar	12 sho		19a. Informant's Name/Relationship (Typ						City or Town, State	
	1 and Health em 27 ither tr		Esther N. Nicholso	n/liother	20b. Place of Dispos	sition (Name of	1		, MD 2180 Oc. Location - City of	
JOI	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Springhi	natory or other place 11 Memory S	8/23		Hebron, M	
Baltimore,	arte arte inju		21. Signature of Funeral Service Lice se	9	22	Name and Address	s of Facility			
m	Den y		> Toels of & su	en (ES	ρ $\frac{H}{5}$	olloway F	uneral Ho	ome Profe	essional . ry,_MD 21	Association
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause Obsease or injury	Due to (or as a	consequence of):					Interval Between Onset and Death
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S, P	es tha Igned I	by P	Part II. Other significant conditions cont	ributing to death but	not resulting in the un	iderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ord	equir sen si nould	ted	Cocaine Use					1 🗆 Yes	3 2 □ No 3 □ I	Probably 4 Unknown
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Vital	<u>2</u> 8 €	o Be	25. Was case referred to medical examiner? 1 ¬Yes 2 No	ospital:	2XXER/Outpatient	3□ DOA Othe	26. Place of Death			
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Division	tal or Attendi s after death. bl Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place ol Injun building, etc.	y - At home, larm, stre (Specify)	eet, factory, office		281. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Director Completely filled in b	Medical C	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☑ Medical Examination	cian: To the best of er: On the basis of e and manner state	xamination and/or inv	occurred at the timestigation, in my op	e, date and place, a inion, death occurr	and due to the car ed at the time, dat	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	0 = 1	,	29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
•			Cahilla	LITTL	~~	0 C	ME		AUGUST 20	, 2005
			30. Name and address of person who com	mpleted cause of dea		· ·	STREET,	BALTIMOR	E, MARYLA	ND, 21201
			31. Date filed (Month. Dav. Year)	32 Registrar						

Registrar

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State of Maryland / Department of Health and Mental Hygien ho 05For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bettie Norfolk August 2005 10:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖫 F Yrs Director 215-46-8875 58 May 18,1947 Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 27 is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes XXNo Director Davidsonville Anne Arundel 10e. Street and Number 10g. Citizen of What Country? death 1520 Themes Drive 21035 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hyglene. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Norfolk Mary Hirstuit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Itam 27 is Shannon Norfolk (Daughter) 1520 Themes Drive, Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ò permit, Page Department of Important: If any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 8-8-2005 Annapolis, MD 21. Signature of Funeral Service Censee 22. Name and Address of Facility
Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or can shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mela /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit certificate be executed lait Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.0. 9☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 patient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner J. Peath e Hospitel or Attending Pl 24 hours after death. e Funeral Director: After ti 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 - Mutural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyler stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address a person who complete cause of death (Item 23a) (Type, Print) Rd Ste 300 Annapolis MD Bestgate terris, mo 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registra

		1 - For State Registrar			Ce	tificate	of L	Death			eg. No.	003	27912
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Examine	r	4a. Facility Name (If not institution, Casey House					kvi	lle			4c. Co	ounty of Death	ery
Funeral Director		5. Social Security Number 160-44-3922 Usual Residence of Decedent	6. Sex 7	7. Age (In yrs. last bir 81	thday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 6/28/	^{Year)} 1924	9. Birth Cou CO	place (State or Foreign ntry) lombia
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Saltimore, semit. Pages 1 a Jepartment of Hea Jepartment of Hea mportent: If item in hijury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp 21. Signatur Funeral Service L	ecify)	tate 20b. Place of cemeter	01	Hea	ven	ւ 8	/10	/2005	Sil		pring,Md
Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Pa. Due to (o	used the death. Do rich line. **Recent Consequence of the consequence	Ca	er the mode	of dying	g, such as				Sprin	E, P.A. g, Md20910 Approximate Interval Between Onset and Death
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S ici	o ne	25. Was case referred to medical examiner?	Hospital:	patient 2 ☐ ER/Ou			Othe			(Check only one			hognico
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To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t	Certific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	and 286. Place of	if Injury - At home, far g, etc. (Specify)	rm, str	eet, factory, o	office		1	28f. Location (Str City or Town	eet and \ State)	lumber or Rura	al Route Number,
the Hosp hin 24 hou the Funer mpletely fil	Medical	(Check only 2 Medical E	Physician: To the becaminer: On the base and manner	is of examination and	, death d/or inv	estigation, ir	n my op	pinion, deat	d place, a	ed at the time, da	ite and pla	ace, and due to	the cause(s)
T viit		29b. Signature and tille of certifier	h	~15				number 5635				igned (Month, ust8,2	
State		30. Name and address of person Joseph Kapla 31. Date filed (Month, Day, Year)	n MD 60	of death (Item 23a) (001 Munca gistrar's Signature			111	Rd I	Rock	ville,	Md 2	20855	

DHMH 17 Rev 1/2001

State

Registrar

AUG 10 2005

State of Maryland / Department of Health and Mental Hygien [9]

27913 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 11:31 P M /Medical Trudy E. Obester 2005 July 29. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month Day, Year) 2/1/1920 **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 ☐ F 578-42-1996 85 Yrs Director New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ns 23e or 28a-f show 1 ☐ Yes 2 No Director Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16700 Norbrook Drive 20832 USA death v Funeral item 27 is marked other then "naturel", or items other treumatic event, the Medical Example from 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours after da Hygiene.
I Hygiene.
other then "naturel", or Item 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Š Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transcriber Self Employed mit. Pages 1 and 2 should be file parlment of Health and Mental Hy portant; If item 27 Is marked oth y injury or other treumatic event ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adolph Hofmann Florence Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Richard Obester, Husband 16700 Norbrook Dr.; Olney MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 8/3/2005 Rockville, MD 4 □ Donation 5 □ Other (Specify) permit.
Departr
Imports
eny inju 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Mychin Wholest 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate the Enter of Jordan Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Diabetes Mellitus Tyre II the death certificate be execu Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimers Dementia, Depression 1 Yes 2 No 3 Probably 4 Unknown Completed Hip Fracture (Right) 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 1 Yes 2 🖾 No 1 TYes 2□ No of or Attending Physicien: after death. I Director: After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 No filled in by the funeral 28a. Date of Injury (Month, Pay Year) 7 / 18/05 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 12:00 P M 1 ☐ Yes 2 ☑ No 2 XAccident Patient fell at home 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16700 Norbeck Dr. Olney, MD determined 4 Homicide Home To the Hospitel within 24 hours a To the Funerel I Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signa ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34472 3 30. Name and addless of person who completed cause of deat (them 3a) (Type Print)

Lynne Diggs M.D. 10400 Connecticut Ave #206; Kensington MD 20895 31. Date filed (Month, Day, Year) State 32. Registrar's Signature AUG 11 2005 Registra

			For State Registrar	State o	of Maryla	nd / Depa <i>Cei</i>	artmen <i>rtificate</i>	t of H e of L	lealth a D <i>eath</i>	and N	dental Hyg	giene Reg. No.	05	2	7914
ri.	Physic		Decedent's Name (First, Mide Mary	Josephin	P	0'Grad	v				2. Date of Dea Month	ath Day		ear	3. Time of Death
1	/Medi Exami		4a. Facility Name (If not instituti			o orau		Town, or	Location of	f Death	August		, 200		6:10 a.m.
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1	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birt	h	-	Distant.	/61.1
	Director	ij.	011-14-0787	1 ☐ M 2 🐼 F	84	Yrs.	Months	Days	Hours	Min.	Oct. 12	$\frac{V_{i}}{2}, \frac{Y_{\Theta ar}}{19}$	20 Ma	Count 3.SS2	ace (State or Foreign ry) chusetts
	pu .		Usual Residence of Decedent 10a, State 10b, Count		10- 6	Site. Towns of									
	eho	7		,	100.0	City, Town or Lo								10	d. Inside City Limits
	the N	ecto	Maryland St.	Mary's				1ywo	od						1 ☐ Yes 2 ® No
	with a or	ă		.1 17			10f. Zip					10g. Citiz	en of Wha	t Count	ry?
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"	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Iteme 23e or 28e-f show event, the Medical Examinar must be inclified at	Funeral Director	1 Never Married 2 Ma	Armed Fo	orces?	0.5.	f Yes, spec	ify Cuba	n, Mexican,	Puerto	ecify Yes or No- Rican, etc.)		4. Race Black, \	America White, e	in Indian, itc.
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21	within 7 ene. than "r	pie	Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	life. L	kind of wor DO NOT us	rk done d e retired,	furing most)	of work	ing				,
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nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle	, Last)					18. Mother	's Name	(First, Middle,				
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lar	2 2 2 3 3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		19a. Informant's Name/Relation								l Route Numbe				
	s 1 and if Health item 27 other tr		Kevin O'Grady	/ Son		24185	Grat	efu:	l Way,		11ywood	, Ma	ry1an	d 2	0636
0			20a. Method of Disposition 1 ■ Burial 2 ☐ Cremation	3 □Removal from	State 20b.	Place of Dispo- cemetery, crem	sition (Nam natory or ot	ne of ther place	9)		ate	20c. Loc	ation - City	y or Tov	m, State
Ë	tmen tant:		4 Donation 5 Other	Specify)	Şt.	John's	Ceme	tery	y 8-	-19-	2005	Holly	wood	, Ma	aryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fursial Service	Licensee		22	. Name and	d Addres	s of Facility	Bri	nsfield	Fune	eral	Ноте	P.A.
	40240		Tyte M	w.	M0120	0 22	900 H	10 T T Z	/wood	Koa	d. Leona	ardto	own,	MD :	20650-0279
	Pnysician		23a Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	aused the dea	ath. Do not ente	er the mode	of dying	, such as c	atous	r respiratory arr	est,			Approximate nt I al Between On et and Dea
	/Medical		disease or condition resulting in death)	a	or as a sonse	auente of):	eno	y	har	KU	16.7	_	- 0-	4	nz
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	icate be executed physicien and s the burial-transit	Examiner	it any, leaving to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(Vo	2000	IZU	170	182	11	2	_		0	421
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9 ×			IF FEMALE:	20. 11		72									
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 Fet	al death 3 🗌	Ectopic pre					23	d. Date of Month		ay Year
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م:	that the by ed by detail	F.	Part II. Other significant conditi	ons contributing to de	eath but not re	sulting in the un	derlying ca	use ane	o in Part I		23e Did tot	22000 1100	contribut	a to the	cause of death?
Division of Vital Records,	uires tha signed d be del	d by					donying ca	uso givo	irairaiti.			s 2			oly 4 □Unknown
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ŏ	Phys rathis	<u>P</u>	1 Yes 2 No	28a. Date o		ER/Outpatient			+ Contract		ne 5 ☐ Reside			Specify)	
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18	l or Attending Physician: The las elter deauter. Director: After this certificate has I in by the funeral director, page 2	fica	3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	nome, farm, stre			65 Z [] NO		8f. Location (St.	mat and	Vicionia		2
á	alor A sefter Il Dire	Certification:	4 Homicide determ	buildin	ng, etc. (Speci	ify)	or, ractory,	Office		-	City or Town	, State)	vurnoer or	Hurai F	toute Number,
	To the Hospital within 24 hours e To the Funeral (completely filled		29a. Certifier 1 Certifyii	ng Physician: To the	best of my kn	owledge, death	occurred a	t the time	e, date and	place, a	nd due to the ca	luse(s) ar	nd manner	as stat	ed.
	To the H within 24 To the F complete	ledical	one)	and man	isis of examini	ation and/or inve	estigation, i	in my opi	nion, death	occurre	d at the time, da	ate and pl	ace, and o	due to th	ie cause(s)
	No To Mit	Σ	29b. Signature and title of certifie	Ul	- 1	_111	29c.	License	number	111	29	9d. Date s	signed (Mo	onth, Da	y, Year)
•			· /2	mest. H	WW VO	57 M		5	06	セレア		8-	17-	05	
			30. Name and address of person	- 11	•		.,								
			J. Patrick 3		D., 240 egistrar's Signa	035 Thre	ee Not	tch :	Road,	Ho1	lywood,	Mar	yland	20	636
	Sta Registr		AUG 1	2005	agiati ai s aighi	K L	وكلمه								

			1 - For State Registrar	ate of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygiene	
P	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month Day	3. Time of Death
	/Medio	al	CLARA LOUISE OST 4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death	JULY 28	2005 11:15 A ^M County of Death
	Examir	ier	104 WOODS ROAD		QUEENSTOWN		QUEEN ANNE'S
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		8. Date of Birth (Month, Dey, Year)	Birthplace (State or Foreign Country)
	Director		070-12-4100 ^{1□ M}	84 Yrs.		APR. 20, 19	921 NY
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation		10d. Inside City Limits
	Man e-f sh	ctor	MD QUEEN ANNE	S QUEENST	OWN		1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. Citi	zen of What Country?
	or death with the Marylan tems 23a or 28e-f show sermant ternatified at		104 WOODS ROAD	Daniel Coming II C	21658	USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28e-f show other treumatic event, the Medical Examinatings to notified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. 13 med Forces? YNo Yes, Give ear or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecry Yes of No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
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121	within ene. then "	mple	Elementary/Secondary (0-12)	bllege (1-4or 5+)	DO NOT use retired)		TID CIT
42	filed v Hygie other t		17. Father's Name (First, Middle, Last)	2 SEC	RETARY 18. Mother's Name	e (First, Middle, Maiden	JRCH Sumame)
Maryland	id be ental ked o	To Be	WILLIAM UNGER			BIRCHLER	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type, P.	int) 19b. Mai	ling Address (Street and Number or Run		r Town, State, Zip Code)
	and 2 salth a n 27 is		BERNARD JOEL OST/HUS	A STATE OF THE PARTY OF THE PAR	WOODS ROAD, QUEENS	STOWN, MD 2	21658
Baltimore,	permit. Pages 1 Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposemetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeters, control of the c	E CREMATION 07 (2)		cation - City or Town, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	2/4.	22. Name and Address of Facility FELLOWS, HELFENBEIN LOG SHAMROCK ROAD,	N & NEWNAM I CHESTER, MI	FUNERAL HOME, P.A.
,1260,	Physician /Medical Examiner portion and partial-transit principle of the	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	se on each line.	The mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of th	-	Approximate Interval Between Onset and Death Months
.O. Box 68	death certific e attending p d for use as f	Physician/Medic	in the past 12 months?		□Ectopic pregnancy □ Other (specify)	2	23d. Date of delivery Month Day Year
S, D	The law requires that the tite has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contribut		, ,	23e. Did tobacco u	se contribute to the cause of death?
Vital Records,	w require been si should t	ted	Chronic Obstructive	pulmonery di	sease	1 Yes 2	No 3 Probably 4 □Unknown
ec	alawi hasbe e2st	Completed	Hypertensian			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al F	rcate		Atrial Fibrillation	?		performed? 1 ☐ Yes 2 No	death? 1 Yes 2 No
ξ	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospita	al: 1 Inpatient 2 ER/Outpatie		n <i>(Check only one)</i> me Mesidence 6	O TOther (Consist)
ion of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	ation; To		a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how injury	
Division	tel or Atters after de al Directo	Certification;	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dirticompletely filled in I	edical	one) 2 Medical Examinar: C	To the best of my knowledge, dea in the basis of examination and/or individual manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)
	To To	≥	29b. Signature and title of certifier		29c. License number OM 1339	29d. Date	e signed (Month, Dey, Year)
7	, 1		30. Name and address of person who complete	and cause of death (from 22a) (T =		17,	131/05
ì Î	OFF		Sant E Hemi mo	ed cause of death (Item 23a) (Type	POINT RO STE	EVENTY, LLE	MO 21666
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		/	
DH	Registr MH 17 Rev 1/2		AUG - 1 2005	Beeve St.	Sport		
				ORIGIN	T AL		1100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.05

27016

			1 - For State Registrar	State of M	,		tificate of L			eg. No.		21910
	Physici	an	Decedent's Name (First, Middle, I	.ast)	PRIC				2. Date of Dea		(өаг	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number		-		Location of Death	Mug	4c. County of	Death	ZOIPM
	Évaium	1ÇI	1315 OLD PISCATAV					SHINGTON		PRINCE		RGES
	Funeral			16/M 20 E	ge (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign ry)
l.	Director		220-32-6441 Usual Residence of Decedent	X	69	Yrs.			NOV. 23	, 1935	MARY	
	ryland thow	_	10a. State 10b. County		10c. City, Town	n or Loc	ation				10	d. Inside City Limits
	the Marylar 28a-f show notified at	ecto		GEORGES	FORT	WAS	HINGTON					1 X Yes 2 □ No
	with t	Funeral Director	10e. Street and Number 1315 OLD PISCATA	WAY ROAD			10f. Zip Code 2074	/ı		0g. Citizen of Wh UNITED S		•
	death	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	<u> </u>		14. Race -	America	n Indian,
21215-0036	within 72 hours after death with the Maryland ane then "netural; or items 23s or 28a-f show a Madical Exercipe ten politied at	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced				Yes, specify Cuba ☐ Yes 2 X No	Specify:	o Hican, etc.)	Specify:	White, e	
15-(c * 1	Completed	15. Decedent's (Specify only highest of		16a.	(Give k	ent's Usual Occupa ind of work done of O NOT use retired	luring most of wor		16b. Kind of Busin		es county
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	d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, La	,				18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)		
Maryland	Men Men arke	2	SHIRLEY BENJAMIN 19a. Informant's Name/Relationship			A 4 - 10'	111 (0)		COOPER			
Ma	d 2 s th ar 7 is treu		FLOYD ROBERT PRI				OOSECREE		ral Route Number,	City or Town, St.		
ore,	ges 1 and 2 of Health If item 27	10	20a. Method of Disposition 1 X Burial 2 □ Cremation 3		20b. Place of	Dispos	ition (Name of atory or other place		_	20c. Location - Ci		
altimore,			`4 □Donation 5 □ Other (Spec			•	ETERANS		6/05	CHELTENH	AM,	MARYLAND
Bal	permit. Pag Department Important; eny injury o		21. Signature of Funeral Service Lic LYDIA C. THOR	TON JOHNSO	N M00583	TH 34	Name and Addres ORNTON F 39 LIVIN	UNERAL H GSTON RO	OME, P.A AD, INDL	ÅN HEAD,	MD	20640
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do n	not enter	the mode of dying	, such as cardiac	or respiratory arre	est,	í	Approximate nterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence of	DIO	suc (over	prov	rac	5	zylan
	Examiner		Conventinity list conditions	b.	a consequence (٥١).						O
	and sit	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of	of):						
,	execut n and al-tran	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	of):					-	
68760	rtificate be executed ng physician and as the burial-transit			d								
		Medical	IF FEMALE:									
Вох	death ce e attendi d for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		ctopic pregnancy Other (specify)			23d. Date o Month		yay Year
0	that the ded by the detached	hysid	1 Yes 2 No 9 Unknown	9□ Unknown	time or death	3 🗆 (Duter (specify)					
s, P		by P	Part II. Other significant conditions	contributing to death b	ut not resulting in	the unc	lerlying cause give	л in Part I.	23e. Did tob	acco use contribu	ite to the	cause of death?
ord	faw requires as been sign 2 should be								1 ☐ Ye	s 2 7 No 3[☐ Probat	oly 4 □Unknown
Rec	9 4 9	Completed							24a. Was ar autopsy perform	/ prio	r to comp	y findings available pletion of cause of
	t icien : Th certificate rector, pag	0	25. Was case referred to medical					26 Place of Deat		2 No 1□	Yes 2	□ No
of V	tending Physicien: Jeath. tor: After this certific the funeral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie		patient	3□ DOA Othe			nce 6 Other ((Specify)	
		ion:	27. Manner of Death 1. Natural 5 Pending	28a. Date of Inju (Month, Day	ry 28b. T y Year) In	ime of jury	28c. Injury Work		28d. Describe how	w injury occurred		
Division	f or Attending after death. Director: After	ficat	2 Accident investigation 3 Suicide 6 Could not determine	be Ose Bless of Init	ury - At home, far	m, stree		es 2 No	28f. Location (Str.	eet and Number o	or Rural F	Route Number
=	tel or A rs after al Dire ed in by	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)				City or Town,	State)		,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	hysicien: To the best miner: On the basis of and manner sta	examination and	death of	occurred at the time stigation, in my opi	e, date and place, inion, death occur	and due to the carred at the time, da	use(s) and manne te and place, and	er as stat	ed. ne cause(s)
	within 2 To the complet	Med	29b. Signature and title of certifier	A Inditiner Sta			29c. License			d. Date signed (A		
		4	Horal &	Hent?	h un		D	21438		Duam	#	112015
1	B		30. Name and address of person who	completed cause of d	eath (Item 23a) (Туре Р	int)	= Him	MALA A	ONAPOLI	, M	An Juni
-	Stat Registra		31. Date filed (Month, Day, Year)	2005 32. Registra	ar's Signature	1111	C. W.	- 1 191	wright	O LAKE OF	١٠١ د	y 1.701

State of Maryland / Department of Health and Mental Hygie20051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August Gloria Pavel 2ď05 2:30 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel General Hospital Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 29 **Funeral** 9. Birthplace (State or Foreign Days Hours 1 □ M 2X F 196-26-0863 81 Director 1924 Pennsylvania Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Eranicar roust be notified at 10d. Inside City Limits Director Prince Georges 1 XYes 2 ☐ No Lanham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6301 Cheswold Place 20706 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by ₩idowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Children's Hospital .. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 is marked other? jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Petrush Mary Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Pavel Son 6301 Cheswold Place Lanham, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 13, 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 2005 Clinton, MD 21. Signatur Funeral Service Licent Rendon Halle Funeral Home 9013 Annapolis Rd. Lanham, MD 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) enal Failure R Pnysician /Medical Due to (or as a consequence of): Examiner Hepatro Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed - Iver Cancer Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificete 2 🗆 No 1 ☐ Yes 2 1 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this ieral Director: After th filled in by the funeral 27. Manna of Death 1 Natural 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 700058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doward Voung MD Anne Armold Medical Centre Annapolis MD 2140 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 2 2005 Registrar

			= State Registrar	e of Maryla	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and N Death	R	eg. No.	27918				
п	Physici	an	Decedent's Name (First, Middle, Last) DDACAD TOCEDIL DAT	T TD AMITT A				2. Date of Deat Month	Day Yes					
T.	/Media	al	PRASAD JOSEPH PAI 4a. Facility Name (If not institution, give street and	LIPAMULA		Ah City Town o	r Location of Death	August	04 200 4c. County of D					
	Examir	ier	Suburban Hospital	a mumbery		Bethes			Montgo					
	Funeral		Social Security Number 6. Sex		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)				
l.	Director		219.08.3750 ^{1⊠M 2□}	61	Yrs.	Months Days	Hours Min.	Dec. 25	, 1943	Country) India				
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits				
	Maryll f sho	ō	Maryland Montgomery		ermanto					14 Yes 2 □ No				
	28a	Director	10e. Street and Number		CIMATIC	10f. Zip Code		1	10g. Citizen of What Country?					
	h with	ai D	18325 Allspice Drive			20874			U.S.A.					
336	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show iteal Exament institut at	by Funerai	11. Marital Status 12. Was Ame 1 Never Married 2 🖾 Married 1 🗋 Yes	Decedent Ever in the following the second se		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	mencan Indian, Ihite, etc. Asian				
2-0	72 hours natural', jical Ex	Completed by	15. Decedent's Education (Specify only highest grade comple	do ell	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	ss/Industry				
21	within 7 ene. than "r	npie		ge (1-4or 5+)	life.	DO NOT use retired	during most of work d)	ing	Southlan	d				
121	ss 1 and 2 should be filed within 72 ho of Health and Menial Hygiene. I fitem 27 is marked othar than "natur r other traumatic avent, the Medical			Years		Accountan			Corporat	ion				
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last)	linomula			18. Mother's Nam							
Z		٩	Joseph Buckiah Pall 19a. Informant's Name/Relationship (Type, Print,	lipamula	19b Mailin	na Address /Street	Kanthan and Number or Rur		Zin Codel					
	nd 2 salth ar alth ar 27 is		Rita Pallipamula/Wife	,						1and 20874				
Jre,	A First Page		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place			20c. Location - City					
im			1 ⊠Burial 2 □ Cremation 3 □ Removal f '4 □ Donation 5 □ Other (Specify)	rom State Ge			Cem.8/10	0/2005	Adelphi,	Maryland				
Baltimore,	parmit. Departm Importa any inju		21. Signature of Funeral Service Licensee	tie	H 1	Name and Addre INES-RINA 1800 New	ss of Facility LDI FUNE Hampshire	RAL HOME Ave, S	INC.	ing, MD 20904				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failire. List only one cause on each line.											
	Pnysician	i	Immediate Cause (Final disease or condition Mu	ltiple Or				1	1	Onset and Death				
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_	rtifica ng ph		IF FEMALE:			Pol-	,							
.O. Box	that the death certiff led by the attending detached for use as	hysiclan/M	23b. Was decedent pregnant in the past 12 months?	, outcome of pregn ive birth 2 ☐ Feta regnant at time of d Inknown	al death 3 □	Ectopic pregnancy Other (specify)	·		23d. Date of o Month	delivery Day Year				
σ	w requires that the been signed by th should be detache	by Pr	Part II. Other significant conditions contributing	to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?				
ord	equire en sig	ted	Acute Renal Failure					1 □ Ye	s 2.MarNo 3⊡	Probably 4 Unknown				
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			1.	26. Place of Deati	Check only one))					
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á	s after	Certification:	4 Homicide	wilding, etc. (Speci	(y) p		3	V RTZ	State) Gerr	nantoun,				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only 1 ☐ Certifying Physicien: To (Check only 2 ☐ Medicel Exeminer: On the	the best of my kno	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner	as stated: ue to the cause(s)				
	To the To the Comp	ž	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mo	nth, Day, Year)				
١	(p		July mo			29	1018		8/4/05					
			30. Name and address of person who completed			_	71 -							
			31. Date filed (Month, Day, Year)	Meles Registrar's Sign	York atura	Pr.	Sler Spin	wo						
	Sta Registra		AUG 11 2005	2 Registrar's Signal	by Box	ale								

			1 - State Registrar	State of		d / Depa		of H	ealth and	Mental Hy			27919	
	Physici	an	1. Decedent's Name (First, Middle	e, Last)						2. Date of D		Year	3. Time of Death	
	Physici /Medic	_	MARION DALE PI							August	06	200.		
4	Examin	er	4a. Facility Name (If not institution	-	mber)		4b. City, Town, or Location of Death Silver Spring			ath		ounty of Deat		
			Holy Cross Hos 5. Social Security Number	pital 6. Sex	7. Age (In yrs.	last hirthday)	Sil ⁻ If Under		Spring If Under 24 H	rs. 9 Date of B		ntgome:		
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	ס		Usual Residence of Decedent									-7 50.		
	arylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo							10d. Inside City Limits †√√Yes 2 □ No	
	he M	ecto	MD Montg 10e. Street and Number	omery	Ke	nsingt		0.4.			10- 02-			
	with la or 3	Funeral Director					10f. Zip					n of What Co	•	
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Itams 23e or 28a-f show any injury of other traumatic event, the Medical Examin or must be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Mar	ned 1 TYPes	2□No WW.	TT 1	If Yes, spec 1 ☐ Yes 2			erto Rican, etc.)	1	Black, White pec <i>ify:</i> White		
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an	ld be ental ked o	To Be	Ellis Rosenkra	•						na Belle		,		
Maryland	shou ind M mar	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a		Rural Route Numi		own, State, Z	ip Code)	
	alth a alth a 27 is		Karen Sue Pitt	s, Daught	er	11117	Lund	Plac	ce, Ken	sington,	MD 20	MD 20895		
Baltimore,	of Hei		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Demoval from	20b. P	lace of Dispo emetery, cre	osition (Nam matory or ot	e of ther place	9)	Date	20c. Loca	tion - City or	Town, State	
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3alt	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee		2	2. Name and	d Addres	s of Facility H	ines-Rin	aldi E	uneral	Home, Inc.	
	0 0 F 4 0		nunya	Muaul		1	1800 1	iew 1	lampshí	re Ave S	ilver	Spring	MD 20904 Approximate	
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	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) CHECK ONLY 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my kno pasis of examina iner stated.	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	e, date and pla inion, death oc	ce, and due to the curred at the time	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)	
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,	7		P WW	NOW N	el	5		9000	2520		Augus	t 8, 2	005	
	'		30. Name and address of person				,							
	-04	• 0	Maria D'Arbela 31. Date filed (Month, Day, Year,	M.D. 15	00 Fore Registrar's Signa	st Gle		d, S	ilver S	Spring, N	D 209	10		
	Sta	te	AUG 11	2005	Registrar's Signa	4 ho	aske							

State of Maryland / Department of Health and Mental Hygien 05 For State Registra Certificate of Death Req. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 1215 William Woolford Parrott /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NICOMICO 50/13644 KegioNal Medical eninsula 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 1 M M 2 □ F Yrs. 213-14-7349 9/28/1919 Director Maryland Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "natural", or iteme 23a or 28a-f show the Medical Experiment must be rediffed at 1 Yes 2 No Maryland Wicomico Completed by Funeral Director Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28573 Ocean Gateway 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Systems Operations Power Company other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked othing any linjury or other treumatic event ones. Be William Reddick Parrott Lillie Woolford ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotta W. Parrott/wife 28573 Ocean Gateway, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 8/12/05 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Parsons Cemetery ignature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association COCCEPTODO CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCIN OMA-UNKNOWN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Division of Vital To the Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the i 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifier 29c. License number August 8, 2005 D55658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Arena, MD 100 E. Carroll St., Salisbury, MD 21801 31. Date liled (Month Par Yar) 2 2005 State Registrar

State of Maryland / Department of Health and Mental Hygien 2005

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			1 - Stete Registrar	•	Certificate of	Death		Reg. No.		
	Physic	ion	1. Decedent's Name (First, Middle,				Date of Death Month	Day Year	3. Time of Death	
	/Medi		Mary	Elizabeth	Propst		August 9,	2005	6:59 P M	
	Examir	ner	4a. Facility Name (If not institution, g		4b. City, Town, o	or Location of Death		4c. County of Death		
			Cumberland Villa		Cumber			Alleg	gany	
	Funeral			. Sex 7. Age (In yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign intry)	
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	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits	
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	with	급		1 D 1	10f. Zip Code		10g	. Citizen of What Cou	intry?	
	s 23	erai	17406 Manife			21555		USA		
	iter d	Ë	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No	J.S. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec ean, Mexican, Puerto R	ican, etc.)	14. Race - Ameri Black, White	can Indian, , etc.	
36	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Exam an outsit by codified at	Completed by Funeral Director	15. Decedent's		16a. Decedent's Usual Occup	nation	16	b. Kind of Business/Ir		
5	n 72	plet	(Specify only highest	rade completed)	(Give kind of work done life. DO NOT use retire	during most of working	9	b. Killd of Eddinessyll	idustry	
212	iene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker			Homemake	er	
p	Hygie other ent,	a)	17. Father's Name (First, Middle, La	st)		18. Mother's Name	(First, Middle, Ma.	iden Sumame)		
Maryland	2 should be filed within n and Mental Hygiene. Is marked other than " raumatic event, the Mer	To B	Marvin	Pete	Thompson	Marion	Ed	lna Bo	sley	
ary	shound N	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	and Number or Rural	Route Number, C	ber, City or Town, State, Zip Code)		
	Tand 2 Health a tem 27 is		Fred M. Propst, Sr.	/ husband	17406 Maniford H				ŕ	
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, The Medical Examinar must be invitted at		20a. Method of Disposition	20b. I	Place of Disposition (Name of cometery, crematory or other place			c. Location - City or To	own, State	
Ĕ	Pages nent of H ant: If ite ury or of		1 ABurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	Di tellioval ilolli otate		l l	005	Sumbouland N	(a erra 1 ara d	
Baltimore,			21. Signature of Fu eral Service Lic	1 111.	llcrest Memorial Pa	ark 08/13/2 ess of Facility Adam		Cumberland, M		
ã	permit Depart Import any in		1 V dent C	Colone		ır Street, Cu	-	•		
			•	Approximate						
	Dhysisian		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	y one cause on each line.					Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	gestile hear	Janus			2 weeks	
U	Examiner			Due to (or as a consec	gestive hear	· deles	0			
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to for as a conseq) wine 2	_		20 years	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć,	exec n an	Exa	resulting in death) Last	C Due to (or as a conseq	juence of):					
68760,	certificate be executed iding physicien and ise as the burial-transit			N d						
68	ificat g phy as the	Medical		U.						
×		2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy			23d. Date of delive	20/	
Bo	death s atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live birth 2☐Feta 4☐Pregnant at time of d		/		Month	Day Year	
0	the oy the	Physician	9 🗆 Unknown	9□ Unknown						
S, D	the de de	by P	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?	
rds	quires n sign uld be		AL	ad fililla	tion		1 🗌 Yes	2 No 3 Prob	ably 4 Unknown	
8	w requires been s	lete	D	gete		-	24a. Was an	24h Wara auto	psy findings available	
Record	0 - 0	ompleted					autopsy	prior to con	mpletion of cause of	
[a	ician: Th certificate ector, pag	e C	25. Was case referred to medical				1 ☐ Yes 2 🕅	No 1 ☐ Yes	2 No	
Vital		o B	examiner?	Hospital:	EB/Outration 3CI DOA Oth	26. Place of Death (
of	Phys r this ral di	\vdash	27. Manner of Death	1 Inpatient 2 2	ER/Outpatient 3 DOA 28b. Time of 28c. Injun	4 Kinursing Home	 5 Residence d. Describe how in 	6 Other (Specify	<i>(</i>)	
on	ding F h. After funera	tlor	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year)	Injury World	k? Yes 2 □ No	d. Describe rion	njury occurred		
Division	after death. I Director: After	Certification;	3 Suicide 6 Could not	be One Steen of Laine. At he	ome, farm, street, factory, office		Location (Street	t and Number or Rura	/ Route Number	
<u>S</u>	o ir	erti	4 Homicide determine	building, etc. (Specif	y)	20	City or Town, S	tate)	r noute wumber,	
	Hospital of the sale of the sa	C	29a. Certifier Certifying F	hysicien: To the best of my kno	wledge death occurred at the time	no data and place on	d due to the course	-/->	-1-1	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Extended)	miner: On the basis of examina and manner stated.	tion and/or investigation, in my o	pinion, death occurred	at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)	
	o th	Me	29b. Signature and title of certifier	3	29c. License	e number	29d.	Date signed (Month,	Dav. Year)	
			Pot.	Pelms	MD Do	49.81	A	egust 10	,2005	
	3		30. Name and address of person who	completed cause of death //	222) (Tung Brief)	, , , ,	14.	7	1	
	nas		PETE C	HALMOS	123a) (Type, Print)	winston	Court	Cerul	ecland	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		- 5		Md	V3.2	
	Registr		ALIC 1 1 2005	Hank	Angelli 1					

		1 - For Amend Item Registrar 1. Decedent's Name (First, Middle, L			, - Cei	rincate	OI DE		2. Date of De	aath Dav		3. Time of Death
Physicia /Medic		Dino Pompieri							August		005	3:20 p M
Examin	er	4a. Facility Name (If not institution, gr Shady Grove Adver					own, or Loc Ville	cation of Death			county of Death	
Funeral Director		5. Social Security Number 6. 579-42-2507	Sex 7.7 15x 2□ F 7	-	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da July 5	th ay, Year) • 1934	Cor	nplace (State or Foreigr untry) nington, DC
/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	Maryland Montgom	nery	Gern	nantow	n						1 ☐ Yes 2 ☐ No
th the or 28	Directo	10e. Street and Number				10f. Zip 0	ode			10g. Citize	en of What Co	untry?
ath wi	la	12861 Sage Terrac	:e			2087				Unite	d State	S
nit. Pages 1 and 2 should be tilled within 72 hours after death with the Marylan artment of Heath and Mental Hygiene. ortant: If item 27 le marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at a.	by Funerai	11. Marital Status Unk. 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	S? XNo		Was Decede If Yes, specif 1 ☐ Yes 2		nic Origin? (Spe Mexican, Puerto l <i>pecify</i> :	ecity Yes or No Rican, etc.)	- 1	4. Race - Amer Black, White Specify: Whi	e, etc.
72 ho	eted	15. Decedent's (Specify only highest g			16a. Dece	dent's Usual kind of work	Occupation done durin	n ng most of worki	ng	16b. Kind	d of Business/l	ndustry
od within 72 hours aff giene. erthan "natural", or i Ine Modical Exemi	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT use Dr i ver	retired)			Trai	nsporta	tion
of 2 should be filed within ith and Mental Hygiene. 72 le marked other than "I traumatic event, the Market	Be	17. Father's Name (First, Middle, Las Pasquale Pompieri						Mother's Name			umame)	
should nd Mer mark	ဥ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Number or Rura			Town, State, Z	ip Code)
alth al		Matthew Sparacino	/Friend		13600	Deerw	ater	Drive,	Germant	town,	MD 208	74
es 1 and 2 of Health of If item 27 I		20a. Method of Disposition 1										
tant:		*4 □ Donation 5 □ Other (Spec	cify)	Met								
permit. Pages 1 al Department of Hee Important: If item any Injury or ethe once.		21. Signature of Funeral Service Lic	Dousch-	ha	cy/						, 1040	Rockville
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	ed the death line.	h. Do not ent	er the mode	of dying, s	uch as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Strept			eremi	a					7 days
Examiner			Due to (or a	as a conseq	uence of):							
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
icate be executed physician and s the burial-transit	Bue to (or as a consequence of).											
	edicai	^>	d									
ne death cer the attendir thed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23	3d. Date of deli Month	very Day Year
es tha gned se dei	þ	Part II. Other significant conditions CHF	contributing to death	but not res	ulting in the u	ndertying ca	ise given ir	Part I.				the cause of death?
aw law law law law law law law law law l	Completed	Cirrhosis							24a. Was	an	24b. Were au	topsy findings available ompletion of cause of
F 0 6	Сош	Alcohol Dependen	ce						perfo 1 ☐ Yes	ormed? 2 ∑ No	death?	2□ No
Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	. Place of Death				
Phys this ral dii	70	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Ir	njury	ER/Outpatier 28b. Time o		c. Injury at Work?	4 ☐ Nursing Ho	me 5 Resi 28d. Describe			ify)
ding Afte fune	ation	1		Day Year)	Injury	М		2 No				
l or Attending after death. Director: After I in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Flace U	Injury - At ho etc. (Specif		reet, factory,	et, factory, office 28f. Location (Stree City or Town, S		Street and wn, State)	Number or Ru	ral Route Number,	
To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		Physician: To the be aminer: On the basis and manner	of examina								
= - = =	Me	29b. Signature and title of certifier			11	10	License nu	ımber		29d. Date	signed (Month	n, Day, Year)
omp	296. Signature and title of certifier D56868 August 3, 20							005				
To the To the Comp		M			/	!			1			
To th To th		30. Name and address of person wh Rockville, MD 2		f death (Iten	n 23a) (Type,	Print) Jud	le Al	exander,	, MD 99	01 Me	dical	Center Dr.

			For State Registrar	State o	of Marylar	nd / Depa	artment o	f Health ar of Death	nd Mer			5	2792	23
			Decedent's Name (First, Middle, I	Last)			imouto c	Dodin		Date of Death	g. No.		3. Time of D	eath
	ysicia Nedic		Richard Walte	r Rahil	ll, Jr.				Αυ	Month Igust	6,2005	Year D	5:00 j	рм
	amin		4a. Facility Name (If not institution, g		ımber)		4b. City, Tow	n, or Location of	Death		4c. County o	f Death		
			6245 Hawthorn				LaPLata				Charles			
Fun Dire	eral ctor		558-40-4600	Sex M∑M 2□F	7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Ye Months Da			Date of Birth (Month, Day C. 20	, 1931	9. Birthp Call	ace (State or F ity) iforni	Foreign La
and			Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					11	Od. Inside City	Limits
Maryl -1 sho	Maryland Charles LaPl										1 ☐ Yes 2[2 ∏X No
h the	Incit	Director	10e. Street and Number				10f. Zip Coo	le		10	g. Citizen of What Country?		try?	
th wit	d ta		6245 Hawthorn	e Road			20	0646			U.S.A	٠.		
Dattition (c) with yield A 1.2.13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show	xaciner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed F	2 □ No ive		Was Decedent f Yes, specify (I ☐ Yes 2☐	of Hispanic Origin Cuban, Mexican, No Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race Black Specify:	, White,	etc.	
2 hou	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during the completed)							cupation	upation 16			iness/Inc	lustry	
ithin 7	Med	Completed	Elementary/Secondary (0-12)		1-4or 5+)			nne during most d tired)						
led w tygien her th	2		1 2 17. Father's Name (First, Middle, La	2		Chier	Petty	y Offic			.S. Go		nment	
d be fi	C eVer	Be C	Richard Walte:		1 Sr			Viol		Mon		,		
should nd Me	math	ဍ	19a. Informant's Name/Relationship		.1, 51,	- William Control	g Address (Str	eet and Number				itate, Zip	Code)	-
alth a	or trat		Mary Frances I	Rahill	Wife	1		norne R						
ages 1 a of the mit of He m	y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	cemetery, crer	sition (Name o	place) Aug.	Date	2005	oc. Location - C			wl an
Dalli Departme Mportan	any injur once.		21. Signature of Funeral Service Lice			22	. Name and Ad	erans Control of Pacility The Second						
			23a. Pert1. Enter the disease, or co	emplications that	MOO6							lead	Approximate	
Physic	rian		shock, or heart failure. List on Immediate Cause (Final	ly one cause on	each line.	4	11>00						Interval Betwe Onset and De	
/Med	lical		disease or condition resulting in death)	aDue to	(or as a consec		277-00						6 year	_ د
Exami	iner		Sequentially list conditions.	b										
P	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):								
xecut	al-tran	xan	that initiated events resulting in death) Last	c	(or as a consec	quence of):								
cate be executed physician and	e buris	dlcalE		d										
tifficate g phy	as the	0		u	-									
To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending.	ched for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1□Live	atcome of pregn birth 2 ☐ Feta nant at time of a nown	aldeath 3□	Ectopic pregna Other (specify				23d. Date Mont		ry Day Yea	ar
s that	e deta	by Pt	Part II. Other significant conditions	contributing to c	death but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did toba	icco use contrit	oute to th	e cause of dea	ath?
quire:	nld be									1 🗌 Yes	2 No 3	Proba	ably 4 □Unk	known
The law re	age 2 should	Completed					<u>.</u>		_	24a. Was an autopsy perform 1 ☐ Yes 2	pr. ad2 de	ere autorior to consath?	osy findings ava	ailable se of
ian:	ctor, p	BeC	25. Was case referred to medical					26. Place of		heck only one	+		20110	
Physic this ce	al dire	To	examiner? 1 Ues 2 No			ER/Outpatien					ce 6 Other)	
ding P	funera	atlon;	27. Manner of Death 1 A Natural 5 Pending 2 Accident investigat		of Injury oth, Day Year)	28b. Time of Injury		njuryat Work? 1 ∐ Yes 2 ∐ No		Describe how	vinjury occurre	d		
or Atten	in by the funeral director, page	Certifica	3 Suicide 6 Could no determine	be 28e. Plac	e of Injury - At h ling, etc. (Speci					Location (Stre City or Town,	et and Number State)	r or Rura	Route Numbe)F,
Hospita 24 hours Funeral	completely filled	edical C	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the teminer: On the temper	e best of my kno casis of examina oner stated.	owledge, death	n occurred at the	e time, date and ny opinion, death	place, and occurred a	due to the cau It the time, dat	use(s) and man e and place, ar	ner as st	ated. the cause(s)	
To the	Idmoo	Me	29b. Signature and title of certifier				29c. Lic	ense number		290	d. Date signed	(Month, L	Day, Year)	
- » P*			1 3 2	71		M	23	13426		A	ugust	8,	2005	
Same	3		30. Name and address of person who B. Larry Jenk		se of death (Ite			range A	Ave.,				20646	
Re	Sta egistr		31. Date filed (Month, Day, Year) AUG 1 1	32. [gistrar's Sign						,			
		- 1	HUGIT			-/								

DHMH 17 Rev 1/2001

		For State Registrar	State of M	aryland / Depa	artment of H		lental Hygie		27924
Obs i a i		1. Decedent's Name (First, Middle,	Last)				2. Date of Death	Day Year	3. Time of Death
Physici /Medi		SANDRA YOST	RITCH	LE				11 2005	10:45 A M
Examir	ner	4a. Facility Name (If not institution,	•)	4b. City, Town, or			4c. County of Death	
5 1		3801 DR. SAMUEI 5. Social Security Number		ge (In yrs. last birthday)	WALDORF If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	CHARLES 1.0 9 Birth	place (State or Foreign
Funeral Director		234-64-4511	1□M 2⊠F	64 Yrs.	Months Days	Hours Min.	JANUARY	ear) - Cou	ntry) VIRGINIA
P.		Usual Residence of Decedent					JIMOHKI .		
show	5	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Director	MD CHARLE 10e. Street and Number	S	WALDORF	10f. Zip Code		10-	Citizen of What Cou	
with with	Di	3801 DR. SAMUEL	MIIDD ROAD		20601		109.		
death ms 2;	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-	U. S. A.	can Indian,
ours after death with the Maryla reft, or Items 23s or 28e-f shov Examinar must be notified at	Fur	1 Never Married 2 Marrie	Armed Forces? 1 Yes 25	₹No	If Yes, specify Cubar 1 ☐ Yes 2€CNo	n, Mexican, Puerto Specify:	Hican, etc.)	Black, White,	, etc.
uref',	d by	3∰Widowed 4 □ Divorced	Year or Dates:						ITE
n 72 i	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of worki	ing 16b	. Kind of Business/Ir	ndustry
iene.	E O	Elementary/Secondary (0-12)	College (1-4or	5+)	REMENT AN		FF	EDERAL GOV	FRNMENT
al Hyg I othe	Be C	17. Father's Name (First, Middle, L.	ast)				(First, Middle, Mai		
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "neturel", or Items 23a or 28e-1 show reumatic event, the Medical Examinar must be notified at	To	FLOYD WILLIAM Y	OST			ROZELLA	MAE WELI	ING	
2 sho		19a. Informant's Name/Relationshi						ity or Town, State, Zij	
1 and Health em 27 ther t		SAMUEL A. MUDD 20a. Method of Disposition	JR. / SON	3801 20b. Place of Dispo				RF, MD 206 Location - City or T	
ages of of of t: If Ite		1 ☐ Burial 2√CkCremation :		cemetery, crei	natory`or other place		T 12,		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netur any injury or other treumatic event, the Medical Once.		' 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		BRINSFIEL				HARLOTTE H	ALL, MD .HME.,P.A.
Departing Department of the property in the pr		Horn Bro	The Sta					TTE HALL,	
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the death. Do not ent					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CV	all Ce	se Ca	~~~	as lu	~	Onset and Death
/Medical Examiner	П	resulting in death)	Due to (or as	a consequence of):			1	0.	
LAdiiiiiei	<u>.</u>	Sequentially list conditions,	b. Due to for or				WED .		
ted	Examine	cause. Enter Underlying Cause (Disease or injury	Doe to for as	a consectence of).					
be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
0 20	dicai		d						
The law requires that the death certifical tite has been signed by the attending phyage 2 should be detached for use as the	Med	IF FEMALE:					_		
leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of deliv	ery Day Year
at the dea	ysic	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)			Month	Day 16a
res that the signed by be detacted		Part II. Other significant condition	s contributing to death t	out not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobaco	o use contribute to t	he cause of death?
uires n sign lid be	d by						1 ☐ Yes	2 □ No 3 □ rot	pably 4 Unknown
aw require s been si	Completed						24a. Was an	24b. Were auto	opsy findings available
sicien: The law certificate has b irector, page 2 s	mo						autopsy performed	? death?	impletion of cause of
	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	10103	2010
Physicien: r this certific ral director,	은	1 ☐ Yes 2 ☐ to	Hospital: 1 Inpatio			4 🗆 Nulsing Ho	me 5 me sidence	e 6 □Other (Specia	<i>(y)</i>
ling P	ion:	27. Manner of Death 1. ☐ Vatural 5 ☐ Pending		ary 28b. Time of Injury	Work'		28d. Destribe how in	njury occurred	
death ctor: y the	licat	2 Accident investiga 3 Suicide 6 Could no	t ba	iury - At home farm str		es 2 No	28f Location (Street	and Number or Rura	al Route Number
al or after	Certification:	4 Homicide determin	building, et	jury - At home, farm, str tc. <i>(Specify)</i>	301, 14001y, 511100		City or Town, S		111001011001,
ospite hours unere ly fille		29a. Certifier 1 Pertifying (Check only 2 Medical E	Physician: To the best	of my knowledge, death	occurred at the time	e, date and place, a	and due to the cause	e(s) and manner as s	tated.
To the Hospitel or Attending within 24 hours after death. To the Funerel Director; Attercompletely filled in by the tuner	Medical	Une)	xaminer: On the basis o and manner st	ated.					
Vitt	-	29b. Signature and title of certifier	M.W.	00	29c. License	number C	29d.	Date signed (Month,	Day, Year)
		30 Name and address of assess w		double (the Side) (Time	V) d	0 5)	1	5/10/6	- 1
85		30. Name and address of person w	Repeted cause of c	20a (1ype,	Le	Plak	MO	2061	46
Sta	ate	31. Date filed (Month, Day, Year)	32. Redistr	rar's Signature					
Registr	rar	AUG 1	2 2005	eve so s	The same of the sa				

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygie 2005 27925

			1 - For State Registrar	State of Mary	Ce.	rtificate of Dea	a <i>th</i>	Reg. No.) 3	21923			
	Physic		Decedent's Name (First, Middle, La CHERYL LYNNE RE	st) NNER			2. Date of Month	Day	Year	3. Time of Death			
	/Medi Examir		4a. Facility Name (If not institution, giv WASHINGTON COUNTY	e street and number)		4b. City, Town, or Loca	tion of Death ERSTOWN	-	4c. County of Death WASHINGTON				
	Funeral Director	Г	217 74 1000	IDM aNE	n yrs. last birthday) 56 Yrs.	If Under 1 Year If U Months Days Ho	nder 24 Hrs. 8. Date of E urs Min. (Month, OCT.	Birth (Pear) 1948	9. Birthp Cour MA	place (State or Foreign http:/ RYLAND			
	se Maryland	ctor	Usual Residence of Decedent 10a. State MARYLAND WASHT		Oc. City, Town or Lo	ocation HAGER			10d. Inside City Limits 1 ☐ Yes 2 🔏 No				
	23a or 2	Funeral Director	10e. Street and Number 12802 LAURAN ROAD			10f. Zip Code 2174:	2	10g. Citizen of	0g. Citizen of What Country? U.S.A.				
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be natified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hispani f Yes, specify Cuban, Me 1 ☐ Yes 2X No Spe	No- 14. Ra Bla Specia	ce - Americack, White,					
1215-0	vithin 72 ho ne. han "natul e Medical	Completed	15. Decedent's El (Specify only highest grades) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupation kind of work done during DO NOT use retired)		16b. Kind of E		•			
and 2	8 4 2 8	Be	17. Father's Name (First, Middle, Last, WILLIAM HOLLIS CO	Tel Media o Hamo (Friol, Mind				lle, Maiden Sumai		ARD CO.			
Mary	ges 1 and 2 should it of Health and Men it of Health and Men if item 27 is marke or other traumatic.	으	19a. Informant's Name/Relationship (Type, Print) TERRA L. RENNER, DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 618 N. MAIN STREET, BOONSBORO, MARYLAN										
Baltimore, Maryland 21215-0036	permit. Pages 1 ar Department of Hea Important: If item: any injury or other once.		20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory of other place) 8/18/2005 HAGERSTOWN 21. Signature of Funeral Service Lifenale Paul M. Dean BAST FUNERAL HOME BOONSBORO, MARYLA										
	Physician /Medical Examiner		23a. Pak1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SCPS(S) Due to (or as a consequence of):										
	eath certificate be executed attending physician and for use as the burial-transit	Medical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Multisy Due to (or as a co		ntection							
n	000	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ♥☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			ite of deliver	ry Day Year			
cords, P	requires that the een signed by th hould be detache	by	Part II. Dther significant conditions c	ontributing to death but no	ot resulting in the un	iderlying cause given în P		Did tobacco use contribute to the cause of death' 1 □ Yes ﷺ No 3 □ Probably 4 □Unkno					
nec	The la	Completed	Lhronic obit	active pul	perang	disalder,		opsy formed?	prior to com death?	osy findings available npletion of cause of 2 No			
or vital	Physician: Th r this certificate ral director, pag	: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death	Hospital:	2 ER/Outpatient	3 DOA Other: 4 □	lace of Death (Check only Nursing Home 5 Res	idence 6 □Oth)			
DIVISION	r Attending er death. rector: Afte by the fune	Certification;			At home, farm, stre	28c. Injury at Work? M 1 ☐ Yes 2 eet, factory, office	2 □No 28f. Location		w injury occurred Pet and Number or Rural Route Number,				
ָ ב	To the Hospital or Attending Physician: In the Zhours alter death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical Cer	29a. Certifier 162 Certifying Ph	ysician: To the best of my	v knowledge, death	occurred at the time, date estigation, in my opinion,	e and place, and due to the	cause/s) and ma	inner as sta	ated. the cause(s)			
:	To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License numb	per	29d. Date signed	d (Month, D	Day, Year)			
1-1	16		30. Name and address of person who of w. E. Wutzera	completed cause of death	(Item 23a) (Type, F	Print)	lagers town		2174				
	Star Registra		31. Date filed (Month, Day, Year) AUG 16 20	32. Begistrar's S		uk							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 27926 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month HUGU **Physician** 11:20 A-M Richard Joseph RIDENOUR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 13, 1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□ F 232-26-4782 91 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked othar than "naturel", or itams 23a or 28a-f show other traumatic event, the Medical Eraculter transite is titled at 1 Yes 2X No Maryland Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16405 Mt. Tabor Road 21740 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No943—
If Yes, Give Year or Dates: 1946 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 - 8assembly aircraft 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) perrii. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If tiem 27 Is marked oth any injury or other traumatic event paces. Be Milton Ridenour Edith Wissinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty J. Tarsus - daughter 16405 Mt. Tabor Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 17, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorjal Hagerstown, Maryland * 4 □ Donation 5 □ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Elvd., Hagerstown, Maryland 21740 fred h Nestal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death c Cardiomyopathy
ence of):
Myocardial infarction Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1□ Yes 2 No 1 Yes Hospital or Attending Physician: Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0058181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown PEPRA H 382 S. CLEVEland ave.

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 15 2005

32. Pagistrar's Signature

27927

			State Registrar	or Marylar		tificate of I			Reg. No.	21321	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Ye		
	/Medic		Ethel M. Redick 4a. Facility Name (If not institution, give street and n	umber)		4b. City. Town, or	Location of Death	August	13, 2005 4c. County of 0	1.40 F	
	Examin	er	Reeders Memorial Home	,		Boonsbo			Washing		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)	
	Director		171-16-6325 1□M 2□XF	8	7 Yrs.			May 26,		ennsylvania	
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits	
)	ith the Marylar or 28a-f show e notified at	to	MD Washington	Boo	onsboro)				1X Yes 2 □ No	
7	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?	
`	238 c		141 S. Main St.			21713			USA		
1	after death w or Items 23s	Funeral	Armed F		J.S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - A Black, V	American Indian, Vhite, etc.	
36	rs aft	by F	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never	2 MNo live Dates:	1	I□Yes 2√2No	Specify:		Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show he Majical Examiner must be multified at	ted	15. Decedent's Education		16a. Deced	lent's Usual Occup	ation during most of work	iaa	16b. Kind of Busin		
215	thin 7 e. en "n	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	life. (DO NDT use retired	i)	ing		_	
	filed wi Hygien other th		12th		Sec	retary	19 Mother's Name	/First Middle	Public S Maiden Sumame)	chools	
a)(c	9 R D ≥	Be	17. Father's Name (First, Middle, Last)								
Marylan	2 should be and Ment Is marked	ပ	Charles E. Norris 19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street		Blanch	er, City or Town, Sta	te, Zip Code)	
9	1 and 2 s Health ar Iem 27 Is		Walter V. Redick Jr./Hu	sband	1158	Luther D	r., Apt.	40, Hag	erstown,	MD 21740	
) Š	es 1 a of Hea fitem r othe		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from	20b.	Pface of Dispo cemetery, cren	sition (Name of natory or other place	(9:	Date	20c. Location - City	or Town, State	
Į,Ę	Pages ment of ent: If it ury or o		'4 □Donation 5 □ Other (Specify)		arlawn M	emorial Par	k 8/17/		Hagerstow		
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensee	2						uneral Home	
	705 e Q		23a Part Enter the disease or complications that	caused the dea	th. Do not ente)5 N. Pot	omac St.	Hagerst	own, MD 2	1740 Approximate	
rac de			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	4.4		0 [] 0 [121.			Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition aa.	(or as a consec	wince of):	l l	sone.				
	Examiner			End	Sleg	1967	reinter	Disca:	C		
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consec	quence of):	1100	2 1	4			
	ecute and trans	Examiner	Cause (Disease of injury that initiated events c	(or as a conse	whence of):	Herie	Miles	-			
68760,	or Attending Physicien: The law requires that the death certificate be executed ther death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.			(6, 45 4 56, 7)	4401100 01).		,				
687	tificate ig physi as the l	edical	a								
Вох	attending for use	Physician/M	23b. was decedent pregnant	utcome of pregn birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of		
	ed for	sicie	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pre	nant at time of		Other (specify)			Month	Day Year	
P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to	death but not res	sulting in the ur	nderlying cause give	en in Part I	23e. Did to	obacco use contribut	e to the cause of death?	
ds,	signe d be d	d by	Part II. Other significant contributing to	death but not rec	sulling in the di	idenying cause give	SITATE CALL.	1		Probably 4 Dunknown	
SOL	w require been si should I	Completed						24a. Was	an 24b. Wer	autopsy findings available	
Re	The lay	dmo						autop perfo	osy prior rmed? deat	to completion of cause of h?	
ta	iclen: T certificate ector, pa	0	25. Was case referred to medical				26. Place of Deatl			Yes 2□No	
Į.	Physiclen: this certific al director,	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🖒 Nursing Ho	me 5 Resid	dence 6 Other (Specify)	
O L	ding Ph h. After th funeral		27. Manner of Death 28a. Dat 1 ☑Natural 5 ☐ Pending (Mc	of Injury onth, Day Year)	28b. Time of Injury	28c. Injun World	k?	28d. Describe h	now injury occurred		
sio	death. ctor: Afr y the fur	cati	2 Accident investigation				Yes 2 □No	28f Location /6	Street and Number o	r Rural Route Number,	
Division of Vital Records,	after of Direction by	Certification:	determined 200. Flat	ding, etc. (Speci	fy)	eet, factory, office		City or Tox	vn, State)	nulai noute (valliber,	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physicien: To the								
	n 24 h	Medical	(Check only 2 Medical Exeminer: On the and ma	basis of examination of the state of the sta	ation and/or inv	restigation, in my o	pinion, death occurr	ed at the time,	date and place, and	due to the cause(s)	
	To the within To the comp	Ž	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (M	onth, Day, Year)	
	48		Medu	/		D	46561		8-12.05		
	3		30. Name and address of person who completed ca							70	
	Sta	to	Dr. Qadir 20311 31. Date filed (Month, Day, Year) 32.	Lappans Registrar's Sign	Road	Boonsbo	iro, MD 2	21713 3	301-432-84	-/0	
	Sta Registi		AUG 1 5 2005	Registrar's Sign	A. Of	whi					

State of Maryland / Department of Health and Mental Hygien For State Registrar 27928 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anna Rankin Day Year /Medical AUGUST 15 2005 10:23 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 1 ☐ M 2 🛪 F 215-20-7470 92 Director Yrs. May 30, 1913 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f shov 10d. Inside City Limits event, the Medical Evandrar must be notified at Maryland Allegany Lonaconing Director 1⊠Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 11 Church Street 21539 U.S.A. or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☐ Yoo
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☒ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Tube Room Operator** Tire 'n 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ursula Blanche Harvey Be rtment of Health and Mental Prant; If item 27 is marked of njury or other traumatic sve John William McIntyre ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leta Hopwood - Daughter 328 Pear Street, Cumberland, Maryland, 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date August 18, 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Frostburg, Maryland Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2005 permit.
Deportra
Importa
any inju 21. Signature of Fundral 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, MD. 21539 N 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line, Approximate
Interval Between
Onset and Death Pericardial Effusion Immediate Cause (Final I diokathic **Physician** disease or condition resulting in death) /Medical Examiner caquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai as IF FEMALE nse 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death ŏ in the past 12 months?
1 Yes 2 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 should be 1 Tes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy of Vital 1 Yes 2 No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 🗌 Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death s after death. 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58853 AUGUST 6 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. HABIB CHOTANI 130 PENNSYLVANIA AVENUE CUMBERLAND, MARYLAND 21502 AUG 1 31. Date filed (Month) 32. Registrar's Signature State 19 2005 Registrar

		1 - For State RegistrarzMFND#19600			O-		ealth and Death	Mental Hyg	ien 2 0 0	5 27929	
Physicia	an	1. Decedent's Name (First, Middle	e, Last)	J∓≜₹¥7₹₹				2. Date of Deat Month		3. Time of Death	
/Medic			JEAN	Α	ROSSA			AUG.	9, 20	05 1:32 P M	
Examin	er	4a. Facility Name (If not institution				4b. City, Town, or		th	4c. County of		
		ROCKVILLE 5. Social Security Number	NURSING 6. Sex		yrs. last birthday)	ROC	KVILLE If Under 24 Hrs	S. 9 Date of Righ		GOMERY Birthology (State of Foreign	
Funeral Director		335-09-1882 Usual Residence of Decedent	1□M 2 X			Months Days	Hours Min		, 1918	Birthplace (State or Foreign Country) ILLINOIS	
/land		10a. State 10b. County		100	c. City, Town or Lo	ocation				10d. Inside City Limits	
Man P-f sh	ţċ	MD. MONTG	OMERY			ROCKVILL	E			1 XYes 2 No	
th the	lrec	10e. Street and Number		•		10f. Zip Code		10	0g. Citizen of Wha	at Country?	
23a	a	199 ROLLIN	S AVE.				20850		U.S	.А.	
er deg	nne	11. Marital Status	Arme	Decedent Ever d Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.	
rs aft	oy F	1 Never Married 2 Marr 3 Widowed 4 Divorced	11 1 62	es 2 No , Give or Dates:		1 ☐ Yes 2 XNo	Specify:		Specify:	LIUTTE	
2 hour	ed	15. Deceden	t's Education		16a. Dece	dent's Usual Occupa	ation		l 16b. Kind of Busir	WHITE ess/Industry	
9. "hin 7.	pie	(Specify only highest Elementary/Secondary (0-12)		ed) pe (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of wo)	orking			
erthe	Com	10				HOMEMA	KER		HOM	E	
IIIU Z I Z I 3-0030 be filed within 72 hours after death with the Maryland to Hygiene. d other then "neturel", or items 23a or 28e-f show deent. If a Madral Examinat must be notified at	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, N	Maiden Sumame)		
y ld	ို	JOHN_		RZYK				JOSEPHIN			
pariminate, interpretation 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Topartment of Health and Mental Hygiene. San proportant: If item 27 is marked other then "neturel, or items 23a or 28e-1 show any injury or other traumatic event. It a Model Examinet must be notified at once.		19a. Informant's Name/Relations			67,15	ng Address (Street a Danforth	Street:	tural Route Number, McLean	City or Town, Sta VA 2210	te, Zip Code)	
Healt Healt Sem 2		PAUL J. ROSSA	/ SUN	2	Ob. Place of Dispo	sition (Name of	JOILE WEE	- 13 13 - 515	20c. Location - Cit	, 120 2007 1	
Pages tment of tant: If it		1 Burial 2 Cremation 4 Donation 5 Other (S	3 □Removal fr		cemetery, crei	natory or other place		U			
nit. P artme ortan injur		21. Signature of Funeral Service		1		S CREMATO 2. Name and Addres		1-2005	RIVERDA	LE, MU.	
Departing Departing any in sonce.		12/12/1	ramb	eisel	M00091 5	HAMBERS F	UNERAL I	HOME & CRI	EMATORIU	M.P.A.	
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To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours attended. To the Funeral Director. At the state death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner	d									
w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	1 ☐ Li 4 ☐ Pi	outcome of prive birth 2 regnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year	
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ilan: ilan: ortifica ctor, p	Be C	25. Was case referred to medical					26. Place of De	ath (Check only one			
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nding Physath. r: After this le funeral di	ertification;	27. Manner of Death 1	9	ate of Injury Month, Day Yea	28b. Time o ar) Injury	Work	at ? ∕es 2 □ No	28d. Describe ho	w injury occurred		
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To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifyin (Check only one)	Exeminer: On the	the best of my le basis of exa- nanner stated.	knowledge, deat mination and/or in	n occurred at the tim vestigation, in my op	e, date and plac sinion, death occ	e, and due to the ca urred at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)	
To t withi To t	Σ	29b. Signature and title of certifier	1			29c. License	number	29	d. Date signed (A	fonth, Day, Year)	
2/		Hall	our	m.	MI)]	D20367		AUG. 10	, 2005	
	-	35. Name and address of person				·			00055		
		JOEL KA	ALMAN, M				., KOCKV	ILLE, MD.	20850		
Sta Registr		AUG 11	2005	Brem	Signature A	مايه					

Ralph W. Riggin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-5597 State of Maryland / Department of Health and Mental Hygier 0 5 tas Registrar Certificate of Death Reg. No. 27930 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Ralph August 18, 2005 William Riggin РМ 6:10/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Deal Island Marina @ Ralph Abbott Rd Deal Island Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9/15/1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months Days Hours Min. 1⊠M 2□F 219-62-7657 51 Yrs. Maryland Director Usuel Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Wicomico Salisbury Maryland Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5428 E. Nithsdale Dr. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status Amed Follows.
12 Yes 2 No
If Yes, Give Marine
Year or Dates: Corp. 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Entrepenuer Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be f is marked John Calvin Riggin Betty Elizabeth Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 is rr eny injury or other treum 5428 E. Nithsdale Dr., Salisbury, MD 21801 Ruby C. Riggin/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 8/24/05 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility Holloway Funeral Home Professional Association ignature of Funeral Service Licensee and H. Udompoor CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Diphenhydramine intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): sicien Box 68760, Physician/Medical the phy US8 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No atten 3 Ectopic pregnancy ŏ Day 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 D Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No this certificate 1KLYes 2 🗆 No 1 Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Nother (Specify) at SCENE Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1XXes 2 □ No o After thi Pound: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Found: Certification: Division ours after deen 1 Natural 5 Pending 1 ☐ Yes 2 No investigation Subject took many unasom pills 8-18-05 2 Accident 28e. Place of Injury - At home, farm, street, factory, office determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Parking Lot (in parked car)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Parking Lot (in parked car)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Registrar

State

leven & Sparle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 3 2005

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland

August 149, 2005

21201

State of Maryland / Department of Health and Mental Hygie [9] [] 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 355 2005 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Locetion of Death 4c. County of Death undel Coen tune HOSP nen 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Sept. 8,1932 **Funeral** Birthplace (State or Foreign Country) 1□M 2√F 72 Director 213-30-1797 Sept. Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director Queen Annes 1 Yes XXNo Chester 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? "naturel", or items 23e 1906 Harbor Drive death 21619 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturel", or ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Eugene Aisquith Ethel Viola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other traingne. Edward C. Rieken (Son) 1906 Harbor Drive, Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State *4 Donation 5 Dother (Specify) Lakemont Mem. Gardens 8/8/2005 Davidsonville, MD 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yrteriosclerotic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetel death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death Year 5 Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? res 22 No certificate 1 Yes 25. Was case referred to medical examiner?
1 ★ Yes 2 □ No Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the DUTY 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who complete cause of death (Item 23a) (Type, Print)) ones, MD 31. Date filed (Month, Day, Year) AUG 1 0 egistrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 27932 1 - For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** August 10, 2005 11:15 AM Alberta Catherine Rosenberger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Village Nursing Care Center
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Allegany Frostburg If Under 24 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) **Funeral** Hours Days Min. 1 □ M 201 F Months Director 213-22-4471 Usual Residence of Decedent 19-May-1917 Maryland with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Maulical Examiner must be notified at 1 Yes 2 □ No Director Frostburg Maryland Allegany 10e. Street and Number 74 Meshach Frost Village 10g. Citizen of What Country? 10f. Zio Code U.S.A 21532death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other then "naturel", or Itel 1 Never Married 2 Married ☐Yes 2 No f Yes, Give 1 ☐ Yes 2 🗷 No 3altimore, Maryland 21215-0036 Specify: Specify 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Homemaker** 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ John E. Rosenberger Grace La Rue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sh ment of Health and ent: If item 27 ls r 6633 Worthington Dorothy Sunderland Worthington 43085 20b. Place Canada Roan ame of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If any injury or soce. 13-Aug-2005 Finzel Maryland 4 ☐ Donation 5 ☐ Other (Specify) **Finzel Cemetery** 22. Name and Address of Facility 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Dementia year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 00055325 11,2005 Worsether 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nN Wonsock Shin, 48 Tarn Terrace, Frostburg, Maryland 21532 M.D., 31. Date filed (Month, Day, Year) gistrar's Signature State AUG 1 1 2005 Registrar

		•	For State Registrar	State of Maryland / Dep Ce	artment of Health and I <i>rtificate of Death</i>	Mental Hygie		27933
	* ;	ø	Decedent's Name (First, Middle, Last	51)		2. Date of Death	Day Yes	3. Time of Death
	Physici		Elizabeth Robbin	ns Raffa		August 1	Day Year 13, 2005	2:52 AM
4	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deatl		4c. County of Death	
-		354	22204 Bay Arbor V	Vay	Great Mills		St. Mar	y's
	Funeral	5=1	Social Security Number 6. S	T	Il Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreigntry)
×	Director		013-18-5253	95 Yrs.			1910 Mass	achusetts
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	sho	5						1 Yes 2 No
	28a-1	Director	Maryland St. Ma	ary's Great M	101. Zip Code	10a	. Citizen of What Cou	intry?
	with a or	ă						,
	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 show disal Examiner must be notified at	Funeral	22204 Bay Arbon	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	U.S.A.	ican Indian,
	fter d	표	1 Never Married 2 Married	1 □ Yes 2 TaNo		o Rican, etc.)	Black, White,	, etc.
93	urs a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specity:		Specify: Whi	te
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		dent's Usual Occupation	tking 16	b. Kind of Business/Ir	ndustry
21	within 7 ene. than "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)			
21	filed withit Hygiene. other than	50			cretary		Clerical	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. It has the sage or 28e-1 show tiem 27 is marked other than "natural", or items 23e or 28e-1 show other treumatic avent, "he Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)	
y Na	should be nd Mental marked o umatic ave	ည	Edward B. Robbin			C. Bates		
ar	2 sho and ls mu		19a. Informant's Name/Relationship (ng Address (Street and Number or Ru		575	
	Health tam 27 l		Jane C. Downer /		4 Bay Arbor Way G			
Baltimore,	ges 1 If of Ho or oth		20a. Method of Disposition 1 Darial 2 Coremation 3 D	20b. Place of Disp cemetery, cre	matory or other place)		c. Location - City or T	own, State
Ë	Pag ment:		4 □ Donation 5 □ Other (Specification)	DITHULL			arlotte H	
E E	permit. Pages Department of Himportent: If its any injury or of 900ce.		21. Signature of Funeral Service Licer		2. Name and Address of Facility Br			
ш	20229		Edul 1118	- 0	P.O. Box 279 Leon			
1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
Sec.	Physician		Immediate Cause (Final disease or condition	. Failure to	thure			Onset and Death
2	/Medical		resulting in death)	Due to (or as a consequence of):	domentia			
	Examiner		Sequentially list conditions,	. End Stuge	dementia			
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
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Box	death certifii e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 menths?		Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
0.	0 0 0	/slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)			
<u>Ч.</u>	The law requires that the ate has been signed by the bage 2 should be detache	Ph		ontributing to death but not resulting in the	Inderlying cause given in Part I	23e Did tobac	cco use contribute to	the cause of death?
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50	w requir been si should	ted				•		
Vital Records,	e law has b je 2 st	Completed				24a. Was an autopsy	24b. Were auto prior to co	opsy findings available empletion of cause of
<u>=</u>		Cou				performe 1 ☐ Yes 2 🖸	d? death? 1 ☐ Yes	XX No
/ita	Physiclen: The this certificate ral director, pag	Be	25. Was case reterred to medical examiner?			ath (Check only one)		
6	Physic this c	ို	1 Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatie		lome 5X Residenc		fy)
		ii o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
Sio	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not b		M 1 Yes 2 No			
Division		Certification:	4 Homicide determined		reet, factory, office	28f. Localion (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	ospitel or hours afte unerel Dir ly filled in							
71	Fun 4 h	Ica	(Check only 2 Medical Exam	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in	th occurred at the time, date and place ovestigation, in my opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as : and place, and due t	stated. to the cause(s)
U I	To the Hos within 24 h To the Fur completely	Medical	one) 29b. Signalure and title of certifier	and manner stated.	29c. License number	294	. Date signed (Month,	Dav. Year)
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29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0055751 8/10/05

person who completed cause of death (Item 23a) (Type, Print)

Jenifer Schmidt, M.D. 23405 Three Notch Road California, Maryland 20619

State Registrar 31. Date filed (Month, Day, Year)
AUG 1 8 2005

State of Maryland / Department of Health and Mental Hygien 0 0 5 27934 For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** W:07 PM 2005 Minnie B. Scott augus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 1 2 1 923 Washingon County Hospital Washington 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 200 81 Maryland Director 214-76-4954 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel; or items 23e or 28a-1 show any injury or other treumatic event, the Medical Exemple. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Maryland Washington Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1380 Marshall St 21740 Completed by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. XXNever Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Scott 2 Delia Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Haines/Social Worker 1380 Marshall St Hagerstown MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ¹ 4 ☐ Donation Smithsburg Crematory Augl6 2005 Smithsburg MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave Hagerstown MD 21742 23a. Part1. Enter the disease, or comp calions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only energiate on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnan 1 Live birth 2 Fetal death 3 Ectopic pregnancy Dav in the past 12 month 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 2 SHC 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospitei or Attending Physicien: Be 25. Was case referred examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To patient 5 Residence 6 Other (Specify) After this 28c. Injury at Work? f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury atural 5 Pending 2 🗌 No 2 Accident investigation within 24 hours after death To the Funerei Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29c. License numbe 29b. Signature and title of centifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-1 BRULL

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

16

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie2e005Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 3:50 PM STINE, CHARLES August 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL 8. Date of Birth (Month, Day, Year) JAN. 29, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Days Hours Min. Yrs 220-26-7434 1932 Director 73 MARYLAND Usual Residence of Decedent Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examples. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 ☐ No **BOONSBORO** Director WASHINGTON MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21713 19 SCHOOLHOUSE COURT U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR TRUCKING CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AMOS C. STINE, SR. NELLIE NADLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY NALLEY, DAUGHTER-IN-LAW 213 WELDON DRIVE, BOONSBORO, MARYALAND 21713 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/2005 ZION LUTH. CH. CEM. MIDDLETOWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 7606 OLD NATIONAL PIKE 21. Sign ture of Tunaral Service Licensee Paul M. Dean BAST FUNERAL HOME DOONSBORO, MARYLAND 21713 L. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Houte 1-hour /Medical Due to (or as a consequence of): **Examiner** wascular disease theroscerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗆 No the 9 Unknown 9 Unknown signed by del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ should be ena tai 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been sion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 1 Inpatient ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature app 29c. License number ture of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 11110 Medical ompus Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Marie CAS. Registrar DHMH 17 Rev 1/2001

	for State Registrar		State of M	aryland /	Depar	tment of ificate of	Health and I Death	Mental H	ygier		27936
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	3		30. Name and address of pe	r	completed caus	se of dea	rth (Item 23a) (Ty	pe, Pri カ・	nt)	lat.	Tom	CTB	ing Ma		, 7_	,	1.02	7
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	Sta	ite		1 5		Janaral	_ orginators	1										

		,	1- State of Maryland / Department of Health and N Certificate of Death		g. No.	21938	
	Physici	an	1. Decedent's Name (First, Middle, Last) ANNA VIDCINIA CTUDIZ	2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examin	al	ANNA VIRGINIA STURTZ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	AUGUST	12, 2005 4c. County of Dea		
	LAGIIIII	C1	ST VINCENT de PAUL NURSING CENTER FROSTBURG		ALLEGAN		
	Funeral Director		<u> </u>	8. Date of Birth (Month, Day, Feb. 24,	9. Birthplace (State or Foreign Country) Pennsylvania		
	yland iow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	e Mar	ctor	MD Garrett Grantsville			1 ☐ Yes 2X No	
	with th	Director	10e. Street and Number 11887 National Pike	10	g. Citizen of What Co	ountry?	
	Jeath The 23	erai	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Ame		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, Item Medical Evar is writtest by redified at	by Funerai	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	Rican, etc.)	Black, Whit	e, etc. Thite	
5-0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing 1	6b. Kind of Business		
12	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Home		
0 7	illed Hygi othar	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	faiden Sumame)		
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/au	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Company Com		•		
	1 and Health am 27 ther tr		Floyd Platter/Son 131 Hemlock Meadow Dr 20a. Method of Disposition 20b. Place of Disposition (Name of	A IN THE PERSON	SVIIIe, MD		
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	4			
alti	mit. P partme sortan / injur	1	'4 □ Donation 5 □ Other (Specify) Grantsville Cemetery Aug. 21. Signature of Funeral Service □ Censee 22. Name and Address of Facility New York	wman Fun	eral Homes	P.A.	
<u>~</u>	Depa Impo any ii	1	P.O. Box 275, Grand	tsville,	Maryland	21536	
	Fnysician /Medical Examiner		23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or partition resulting in death) Due to (or as a consequence of): Sequentially list conditions.			Approximate Interval Between Onset and Death	
68760,	tificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, it any, leading to find district cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Other (specify)		23d. Date of del Month	ivery Day Year	
	s that ined b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
ğ	w requires that been signed be should be det	ted t	Corenary Artery Disease	1 🗆 Yes	s 2 ∕ o 3 ☐ Pr	obably 4 Unknown	
Vital Records,		Completed	7	24a. Was an autopsy perform	prior to	topsy findings available completion of cause of	
Zi S	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? Hospital: Use of Death Other: Other				
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Divis	or At or At Dirac in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,	
	To the Hospitel or At within 24 hours after or To the Funaral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, dat	te and place, and due	to the cause(s)	
	with To I	Σ	29b. Signature and title of certifier #Chotaul 29c. License number D58853 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I+AB iB C+OTANI 131 Penn sylvanica An	29	d. Date signed (Month	n, Day, Year)	
	le		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ITAB IB CHOTANI 131 Penn sylvania An	e, Cu	mberlan	d, al Daiso	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 5 2005 32. Registrar's Signature				
DH	MH 17 Rev 1/20	-	property for the property of the second				

State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar 27939 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 8 2005 ear 8:25 A M Ursula Lievendag Schwadron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 1409 Woodside Parkway If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 12, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) Months 1 □ M 2 🖾 F 80 Yrs. Director 058-24-4052 1925 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any joury or other traumatic event; the Medical Evantment must be rectified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Direct 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1409 Woodside Parkway 20910 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Caucasian 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adele Zinner Siegbert Lievendag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Woodside Pkwy.; Silver Spring MD 20910 Steven Schwadron / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/9/2005 Clarksburg, MD Garden of Remembrance 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Mycein T. Kleer 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequency of Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 21 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 TrNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 😾 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA illed in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/8/2005 D26259 B 30. Name and address of person who completed gauss of death (Item 23a) (Type, Print)
Dr. Eva Kaufman 8218 Wis. Ave. Rm 103; Bethesda MD Dr. Eva Kaufman 8218 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 - For Stete Registrer	State of M	aryland / Dep <i>Ce</i>	artment ertificate	of He	ealth an Death		giene 2	005	27940
I	Physici		Decedent's Name (First, Middle, Last Marla	-	Schwartz		-		2. Date of De		05 ^{Yeer}	3. Time of Death 1:30A M
	/Medic Examir		4a. Facility Name (If not institution, given	street and number)			rown, or i	Location of D		4c. Coun	ity of Death	1
	Funeral Director		5. Social Security Number 6. S 578-62-7808 1 Usual Residence of Decedent	ex 7. Ag □ M 2 F	e (In yrs. last birthday 56 Yrs.	If Under 1 Months	1 Year Days	Hours I	Min. 8. Date of Bir (Month, Date of May 18)	th Year), 1949	Coun	lace (State or Foreign try) ington, DC
	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturet" or Items 23a or 28e-f show event, the Medical Eractifications to the medical Eractification.	by Funeral Director	10a. State 10b. County Maryland Montgon 10e. Street and Number 5403 Glenwood 11. Marital Status			hesda 10f. Zip (2081		Ur ? (Specify Yes or No Juerto Rican, etc.)	- 14. Ra	f What Coun	of America
Maryland 21215-0036	within 72 hours after ene. then "neturet; or It	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	1 ☐ Yes 2 💥 If Yes, Give Year or Dates:	16a. Dece (Give life.	1 ☐ Yes 2 Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual Redent's Usual	Occupat done du retired)	Specify: tion tring most of		Spec		te
and 2	ld be filed ental Hygie ked other ic event, II	o Be	17. Father's Name (First, Middle, Last) Sam Schwartz		1 110	W DIDI		18. Mother's	Name (First, Middle,	Maiden Suma		versity
	nd 2 should be fall and Mental H 27 Is marked of r treumetic eve	1	19a. Informant's Name/Relationship (Howard A. Morrisc						r Rural Route Number Bethesda,			Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injured, other treumetic engines.		20a. Method of Disposition 1 □ Mourial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		20b. Place of Disp cemetery, cre Garden of	matory or oth	her place,		Date 08/11/05	20c. Location		wn, State , Maryland
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service Licer	see .					eral Direc Pike, Rock	tion,]	Inc.	
8760,	Physician and // Medical Examiner sthe burial-transit	dicai Examiner	23a. Parts of the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	a. Ovariar Due to (or as b. Due to (or as c.	the death. Do not enne. Carcinom. a consequence of): a consequence of): a consequence of):		of dying,	such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
.O. Box 68	death certii e attending ad for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pred ⊒ Other (spec					ate of deliver	ry Day Year
Δ.	sign d be	by	Part II. Other significant conditions c	ontributing to death b	ut not resulting in the u	inderlying car	use given	in Part I,		37		e cause of death?
al Records,		Completed							24a. Was autop perfo 1 Yes	an 24b. osy rmed? 2 No	Were autop prior to con death? 1 \(\subseteq Yes	esy findings available apletion of cause of
Division of Vital	utending Physideath. ctor: After this the funeral di	Certification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	y Year) 28b. Time of Injury	M 28	c. Injury a Work?	4 ☐ Nursin	Death (Check only of ag Home 5 Resided 28d. Describe has 28f. Location (5	dence 6X_Ot	rred	
ā	To the Hospitel or A within 24 hours after To the Funerel Director to the Fune		29a. Certifying Ph	building, etc	c. (Specify)	h occurred at	t the time	, date and pl	City or Tow	m, State)	anner as etc	tod
	To the Ho within 24 I To the Fu completely	Medicai	(Check only 2 ☐ Medicel Exemone) 29b. Signature and title of certifier	iner: On the basis of and manner sta	examination and/or in	vestigation, i	n my opir License r	nion, death o	ccurred at the time,	date and place, 29d. Date signs	, and due to	the cause(s)
)	6		30. Name and address of pason who	completed cause of d	eath (Item 23a) (Type	Print)		D356	35	Augus	t 8, 2	2005
			Joseph Kaplan,	MD 60	001 Muncast	er Mi	11 R	oad, R	ockville,	MD 208	55	
	Sta Registr	-	AUG 11 20	05 Source	ar's Signature	well						

UNKNOWN 05-5304 JACQUENETTE L. SCHMIER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5

		For State Registrar 1. Decedent's Name (First, Middle, Last,	State of Maryla	Ce	rtificate of D	Death	2. Date of De	Reg. No.	3. Time of Death
Physician /Medica Examine	1	Jacquenette L. 4a. Facility Name (If not institution, give OAKLAND ROAD			4b. City, Town, or I	5	AUGUS7	4c. County of E	Peath
Funeral Director		5. Social Security Number 6. Sec 225-88-7805	7. Age (In ye	rs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth 9.	Birthplace (State or Foreign Country) VA
ath with the Maryland 23s or 28s-f show		Usual Residence of Decedent 10a. State 10b. County MD Anne A	arundel 10c.	City, Town or L		lyn Par	k		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23a or 2	Funeral Director	10e. Street and Number 5200 Ballman Avenu	le		10f. Zip Code 212	25		10g. Citizen of Wha	t Country? JSA
lterna Itema	^	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13.	Was Decedent of His If Yes, specify Cuban		Specify Yes or Note 10 Rican, etc.)	o- 14. Race - / Black, V Specify:	American Indian, White, etc. White
Maryland 21215-0036 nd 2 should be filed within 72 hours aff lith and Mental Hygiene. 27 is marked other than "natural, or rirsumatic event, the Mudical Exert	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of wo	orking	16b. Kind of Busine	ess/Industry
Aland 2 Mental Hyg Mental Hyg mksd other attic event,	o Re C	17. Father's Name (First, Middle, Last) Jackson L. Bulloc	ek, Sr.			18. Mother's Na		, Maiden Sumame) E Fitzgera	ld
and 2 sho eaith and I m 27 te mar sar traume		19a. Informant's Name/Relationship (Ty Elizabeth Bull	ock /Mothe	r 5240	Whorton	Bend	Rd Gad		35901
Baltimore, permit. Pages 1 an Department of Heal Important: If Hem 2 mp in yi juury or other page.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	I N	Metro Ci	osition (Name of matory or other place rematory	1-18	Date 11, 2005	20c. Location - City Baltimore	e, MD
Demil Depart Important in Street		21. Signature of Juneral Service Licens	Hlen	49	95 Gov. ri	tchie H	wy, Seve	erna Park,	Funeral Home MD 21146
Physician /Medical Examiner		23a. Pant. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a cons	PIE -		«	c or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	redical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
death ceres attendir	Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3[Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
res the digner of the digner o	2	Part II. Other significant conditions cor	ntributing to death but not r	resulting in the u	inderlying cause giver	n in Part I.		2/	e to the cause of death? Probably 4 Unknown
The age page	Completed						1 Yes	psy prior deal 2 No 1 1	e autopsy findings available to completion of cause of 1? Yes 2 \(\sumbole\) No
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Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: Attenthis completely filled in by the funeral of	Certification:	27. Manner of Death 1 Natural 5 Pending Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 8 - 6 - 0 Y 28e. Ptace of Injury - Al	6:201	S M 1□Y	es 2 No	Driven		I PAU WITH VAI
Divisite or Attent urs after death orel Director:		4 Homicide determined	building, etc. (Spe	wy			OAKLAM	Wn, State) RDHEUDER	Bow Chaocine
ths Hospital thin 24 hours a the Funeral I mpletely filled	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one)	sician: To the best of my kiner: On the basis of exami and manner stated.	ination and/or in	h occurred at the time vestigation, in my opi	e, date and place nion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within To the comple	Σ	29b. Signature and title of certifier	Thele wo	tom 33a) (Tuna	29c. License OCM			AUGUST 7	onth, Day, Year) , 2005
		30. Name and address of person who co	32. Restrar's Sig	111 PE	*	BALTIM	ORE, MAR	RYLAND, 21:	201
State • Registra	r,		400	BA	front				

State of Maryland / Department of Health and Mental Hygiene 005 27942 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 2005 4:45 Strong August Penelope Η. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 327 South River Club House Road Anne Arundel Harwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 6. Sex Months 1 ☐ M 2 5 F Director Dec. 24. 1939 Pennsylvania 578-54-0893 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or items 23a or 28a-f show It e Medical Examiner must be notified at 1 ☐ Yes XXNo Pinellas Indian Rocks 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1510 Gulf Blvd., #206 34635 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4XX ivorced ted 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) 5+ NIH Accountant markad othar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Hoke Eleanor Kramer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1412 Thistle Brooke Court, Crofton, MD 21114 Christopher Strong (Son) othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Important: If it any injury or o once. 1 ☐ Burial 2 XX remation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 8-4-2005 Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License allan en 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreas week **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 1 No Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 No P 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo tha Funarai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ೭ 052830 curine werry and address of person who completed cause of death (Item 23a) Type, Print) MD 900 Bestgate Road #300 Annapolis, MD Canine Werne 31. Date filed (Month, Day Year) 32. Registrar's Signature State AUG 1 0 2000

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygie 20 0 5 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bertha Fern Schwier 2005 10:30p August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Genesis Eldercare - Spa Creek 8. Date of Birth (Month, Day, Yea Dec. 4, 1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F Months 1920 Virginia Director 578-14-1853 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if the 27 is marked other than "neture!" ~ " any injury or other treumetic event." 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 📆 No Director Stevensville MD Queen Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21666 325 Queen Anne Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hood Clarence Cooper ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford A. Schwier (Son) 325 Queen Anne Road, Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prospect U.M. Cem. 8-11-2005 Mt. Airy, MD 22. Name and Address of Facility
Hardesty Funeral Home, PA 21. Signature of Euneral Service Licensee atril 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) alcinoma **Physician** uano as /Medical Due to (or as a consequence of): Examiner notastasu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 3 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2000 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont gistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2005

AUG 10

Amend#20B per FD 8/19/05 AA Cc. Health Dept. lo

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene o or

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			otato of Marylan	Certificate of	Death	Reg. No.	5 2/944
	Physicia	n .	Decedent's Neme (First, Middle, Last)			ete of Deeth onth Day	3. Time of Death
	/Medic		Robert Donald Shea		AL		
	Examin		4e Fecility Neme (If not institution, give street end number)		4b. City, Town, or Location	of Death 4c. County of	Death
			FutureCare Chesapeake		Arnold	Anne	Arundel
	Funeral Director		5. Social Security Number 027-14-6815 Usuel Residence of Decedent 6. Sex 7. Age (In yrs. 10. Mm 2 □ F 81	last birthday) If Under 1 Year Months Days	Hours Min. 8. Da	te of Birth (onth, Day, Yeer) y 21, 1924	9. Birthplace (State or Foreign Country) Massachusetts
	pue *			y, Town or Location			10d. Inside City Limits
	Se-f sho	Director	MD Anne Arundel	Severna	Park		1 ☐ Yes 2 ဩNo
	sath with the Merylenc s 23s or 28s-f show rust be notified at	ral Dire	10e. Street end Number 508 Green Forest Drive		146	10g. Citizen of Wh	et Country? USA
020	urs after de Ni, or Item Fraudner	by Funeral	11. Maritel Stetus 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U, Armed Forces? 1 ☑ Yes, 2 □ No If Yes, Give Year or Dates:	I3. Was Decedent of Hif Yes, specify Cub. III 1□ Yes 2☑ No	dispanic Origin? (Specify Yan, Mexican, Puerto Rican, Specify:	es or No- etc.) 14. Race- Black, Specify:	American Indien, White, etc. White
1215-(within 72 h ene. than "netu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working d)	16b. Kind of Busi	
N	e filed w of Hygier offher th	ខ្ញុ	4	Agen			.B.I.
/land	S G S S	To Be	17. Father's Name (First, Middle, Last) John J. Shea		18. Mother's Name (First, Honora Con	, Middle, Maiden Sumame) neely	
, Mar,	d2sh, thend 7 lem treum		19a. Informant's Name/Relationship (Type, Print) Mary M. Shea/Wife	19b. Mailing Address (Street 508 Green Fo		e Number, City or Town, St Severna Park	
Baltimore, Maryland 21215-0020	# # # # # # # # # # # # # # # # # # #		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	lace of Disposition (Name of emetery, crematory or other please. Patrick Ceme		20c. Location - Ci	
Balt	permit. Peges Depertment of Important: if is any Injury or pace.		21. Signature of aneral Service Licensee		Sons, P.A.	Severna Park Severna Park	Funeral Home
		1	23a. Párt1. Enter the diseese, or complications that caused the death shock, or heart failure. List only one cause on each line.			•	Approximate
A.	Physician /Medical Examiner	e	Immediate Ceuse (Final disease or condition resulting in death) a	A G E DEM r as e consequence of):			Interval Between Onset and Death
,	executed n end iel-trensit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	r as e consequence of):			
x 68/6U,	artificate be ing physicia e es the bu	Medical		as a consequence of):			
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	het the d ad by the deteched	Dy Pinysician	Part II. Other significant conditions contributing to death but not result	lting in the underlying cause give	en in Part I. 23		bute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O.	w requires that the death cost seen signed by the ettend should be deteched for us.	combiered by			24	a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
<u> </u>	icete he					1 □ Yes 1 ☑ No	1 ☐ Yes 2 ☐ No
5	Iclan: certific rector		25. Was case referred to medical examiner?	=B/Outpatient 3□ DOA Othe	26. Plece of Death (Chec		
5	Physic this correl dire		1 Inpatient 2 E	-rvoutpatient 3L DOA	Auz Nursing nome 51	Residence 6 Other (Specify)
Nois	Attending Physician: r death. sctor: After this certific by the funerel director,	ימנו <u>ס</u>	LØNaturel 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident investigation	Injury Work	Yes 2 No 28d. De	scribe how injury occurred	
	ital or Attending P irs ofter death. al Director: After t led in by the funers		building, etc. (Specify)		City	cation (Street and Number of y or Town, Stete)	
	n 24 hour n 24 hour ne Funer pletely fil	Calca	29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination end manner stated.	on and/or investigation, in my op	olnion, death occurred at the	e time, date and place, and	due to the cause(s)
	To the To the Community of the Community	-	29b. Signature end title of certifier	29c. License	number	29d. Date signed (A	fonth, Day, Year)
			rning, mg	D	57531	Aug 4,	2005
			29b. Signature end title of certifier 30. Neme end eddress of person who completed cause of death (Item: Mohrt Ncg 8601 Vcter 31. Date filed (Month, Day, Year) 32. Registrar's Signature and Control of Signature and Co	23e) (Type, Print) and Hwy M	Messille,	MD 2110	8.
	State		31. Date filed (Month, Day, Year) 32. Regular's Signatu	Ire M A . ro.			

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00:53 SAPP DONALD 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicomico modical CENTO 50/15/11/14 Regional If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Month Day Year APR. 3, 1929 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1**™**M 2□F DELAWARE Director 222-18-4992 Usual Residence of Decedent with the Manyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner nust be notified at 1 Yes 2 No DF. SUSSEX MTI.FORD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19963 20157 CEDAR BEACH RD. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after | ₩ Yes 2 □ No | ¥es, Give 1952–1954 | Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural', or 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other treasment. MECHANIC AUTOMOTIVE 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM HENRY SAPP SR. **ESTELLA JONES** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4160 PARADISE ALLEY RD., HARRINGTON, DE 19952 - DAUGHTER DONNA SAPP 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 N Removal from State MILFORD COMMUNITY CEM.8-22-05 MILFORD, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BERRY-SHORT FUNERAL HOME 21. Signature of Funeral Service Licensee 119 NW FRONT ST., MILFORD, DE 19963 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician /Medical Due to (or as a consequence of) **Examiner** tasmonhei Sequentially list conditions Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of), Examine Due to (or as a consequence of) Box 68760. certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? engion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 ☐ Yes 2 HO Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/18/00 mor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E 31L13bU RMC CAKROI man 2. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	ryland / Depa Ce	artmer <i>rtifica</i>	te of D	ealth and Death		neg. N	2005	279	46
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1	/Medic	cal	Ro 4a. Facility Name (If not institution, giv	se Cecelia	Scriber	4b City	Town or I	ocation of Deat	Augus		0, 2005 c. County of Dea		PM
	Examir	ier	39986 Lady Balti		2	_ ′	npton				St. Mary	_	
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)		r 1 Year	If Under 24 Hrs Hours Min.		rth	9 Birtholace (State or Foreign		
	Director		216-40-9652	ILM 201F	87 Yrs.					-	1918 Ma		
	ehow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside C	ity Limits
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	or 28	Director	10e. Street and Number			10f. Zi	p Code			10g. C	itizen of What C	ountry?	
	s 23a		23960 Budds Creek Roa		110		624	0 /5	land. Van av N		USA 14. Race - Am	adaan ladiaa	<u> </u>
936	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Ifem 27 is marked other than "natural", or items 23a or 28s-1 ehow other treumatic event, the Mudical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	If Yes, sp	2 X No	Mexican, Puer	pecify Yes or Note Rican, etc.)	0-	Black, Whi	te, etc.	
21215-0036	72 hor	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usu	al Occupat	ion iring most of wo	rkina	16b.	Kind of Business	/Industry	
121	Mithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)			iring most of wo	9				
d 2	filed v Hygie other t		6 17. Father's Name (First, Middle, Last)	l	Homema		I8. Mother's Na	ne (First, Middle	1	n Home		
<u>la</u> n	Aental	To Be	James Buster Mills					Della T	nomas				
Maryland	12 should be filed within "n and Mental Hygiene. Fis marked other than "reumatic event, the Men		19a. Informant's Name/Relationship (Турв, Print)	19b. Maili	ng Addres	s (Street ar	nd Number or Ri	ural Route Numb	er, City	or Town, State,	Zip Code)	
	1 and 1ealth om 27 ther tr		Rose Scriber / Daught	er	39986 20b. Place of Dispo			ore Avenu	e, Comptor		ryland 20 Location - City of		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tree		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		cemetery, crea	matory or	other place,	l E	Mugust		,		
altir	mit. Poartme		21. Signature of Funeral Service Lige		Queen of Pe	2. Name a	nd Address	of Facility	5, 2005		en, Maryla	and	
ä	Depar Impor any ir		michael Herr	in Hard	P. P.	.O. Bo	x 270.	Leonardto	neral Home own, Maryl	land	A. 20650		
т		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approxima Interval Bei Onset and	tween
F. ja	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ic Breast	Cano	er					8 Year	
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	- 2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):								
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
68760,	be exelician a	al Ex	resulting in death) Last	Due to (or as a	consequence of):								
282		edical		d									
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75.4					23d. Date of de	livery	
O. B	Q O Q	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4 Pregnant at 1		Other (s	pecify)				Month	Day	Year
Δ.	requires that the leen signed by th hould be detache		Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying	cause giver	in Part I.	23e. Did	tobacco	use contribute t	o the cause of	death?
Records,	quires nn sign uld be	ed by							10	Yes :	2 🔯 No 3 🗆 P	robably 4 🗆	Unknown
000	S S S	Completed							24a. Was		24b. Were a	utopsy findings completion of c	available
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of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other		ath (Check only			Daugh	nter's
o	Phys this ral di	To :	1 ☐ Yes 2 🔯 No 27. Manner of Death	28a. Date of Injur	t 2 ER/Outpatier		OA 28c. Injury a	4 🗀 Nursing r	lome 5 Res		6 ⊠Other (Spe	ecify) Resid	lence
ion	Attending Phirideath.	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	м		s 2 □No					
Division	tei or Atte s after de al Directo ad in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ry - At home, farm, st (Specify)	reet, facto	ry, office		28f. Location (City or To	Street a	and Number or R te)	ural Route Num	nber,
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 X Certifying P (Check only 2 Medical Example) Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner state	examination and/or in	h occurred vestigatio	d at the time n, in my opi	n, date and place nion, death occi	e, and due to the urred at the time,	cause(date ar	s) and manner a nd place, and du	s stated. e to the cause(s	s)
	with Com	Σ	29b. Signature and title of certifier			29	c. License			29d. D	ate signed (Mon	th. Day, Year)	
	Sie		, And				D 200	080	I	lugu	st 15,	2005	
	7		30. Name and address of person who Gurdeep S. Chhabra,		ath (Item 23a) (Type, oint Lookout		Leona	rdtown M	arvland 2	0650			
	> Sta	ate	31. Date filed (Month, Day Year).	32. Regist	s Signature	au	, acona	Lucowii, r.	LI JEGILU Z	5550			
	Registr		arig t	5 2005	مق								

			For State Registra MEND#29	Mrs.	State of Ma	aryland /	Depa	artment of He <i>tificate of E</i>	ealth and Death	Men			005	2794	F []
			Registrary LINDH25 Decedent's Name (First,			<u></u>		tinoato or E	, can	2. [Date of Deatl			3. Time of D	eath
П	Physicia		Bernard	Tı	ıtson					1	Month gust 5	Day	005	12:33	A M
	/Medic Examin		4a. Facility Name (If not ins					4b. City, Town, or	Location of Dea		5000	-	County of Dea		
			Shady Grove	Adve	ntist Hosp	ital		Rockvil	le, MD.			N	Montgor	nery	
	Funeral		5. Social Security Number	6. Se		e (In yrs. last i	birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. C	Date of Birth Month, Day,			thplace (State or a	Foreign
п	Director	ļ	578-22-2843		ZIM 2□F	79	Yrs.	World Bays	110013	No	ov. 21	, 1.9	25Wash	ington I	O.C.
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	Aaryla F sho	5		ontgo	n A 1 ° 37	Rock								X□ Yes 2	
	28a-	Director	10e, Street and Number	Onegoi	пету	KUCK	ATTT.	10f. Zip Code			10	n. Citiza	en of What C	ountry?	
	with 3a or		138 Monroe	Straat				2085	50						
	death ms 2;	Funeral	11. Marital Status	Jereet	12. Was Decedent I	Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cuban		Specify			ed Sta 4. Race - Am	erican Indian,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural", or Itams 23a or 28a-f show event, I'm Medical Ever it at most be recilied at	by Fur	1 ☐ Never Married 2년 3 ☐ Widowed 4 ☐ Div		Armed Forces? 1 XYes 2 ☐ N If Yes, Give Year or Dates:	1944 <u>-</u>			Specify:	erto Rica	n, etc.)	5	Black, Whi Specify: Ne		
9	2 hou atura		15. De	cedent's Ed	ucation		a. Deced	ient's Usual Occupat	tion		1	6b. Kind	d of Business	/Industry	
215	hin 73	Completed	(Specify only Elementary/Secondary (· · · · · ·	de completed) College (1-4or 5	.+)	(Give life. l	kind of work done du DO NOT use retired)	uring most of w	orking				·	
2	e filed within al Hygiene. I other then '	Son			4		Pos	stal Inspe	ector			Po	stal S	ervice	
nd	be file tal Hy d oth	Be	17. Father's Name (First, M						18. Mother's Na		st, Middle, N .nk	faiden S	Sumame)		
<u>ya</u>	2 should be and Mental Is markad of aumatic eve	2	Bernard Tu						Pear1						
Maryland 21215-0036	d 2 st h and 7 Is n traun	g i	19a. Informant's Name/Re-		• • •			g Address (Street ar				•		Zip Code)	
	1 and Healt am 2		20a. Method of Disposition	10150	II / WITE	20b, Place	of Dispo	Monroe St. sition (Name of		V T T T	-		0850 ation - City or	Town, State	
Baltimore,	permit. Pages 1 and 2 should bi Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic en		1 🕅 Burial 2 □ Crem '4 □ Donation 5 □ Ot				-	natory or other place Iemorial		11/0			land,		
Ball	permit Depart Import any in		21. Signature of Funeral 5	301	ces			Name and Address OO Georgi	1	McGu N.	ire Fu W. Wa		al Ser D.C.	vice 20012	
			23a. Part1. Enter the disease shock, or heart silure			the death. D								Approximate	en
	Physician		shock, or heart failure/ List only one cause on each line. Immediate Cause Final Onset and De												ath
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П	Examiner	Ы	Sequentially list conditions	Sequentially list conditions, and fany, leading to immediate b. Due to (or as a consequence of):											
	ed sit	nine	Sequentially list conditions if any, leading to immediate cause Englishers in Cause (Disease or injury	•	Due to (or as	a consequenc	e of):								
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.89	tificating phy as the	ledical						100-				- 1			
.O. Box	death cer e attendir nd for use	Physician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ant	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)		_		23	3d. Date of de Month	livery Day Ye	ar
σ	requires that the leen signed by th hould be detache	y P	Part II. Other significant co	onditions co	ontributing to death b	ut not resulting	in the u	nderlying cause giver	n in Part I.		23e. Did tob	acco us	e contribute t	the cause of dea	ath?
rds	w requires been sign should be	q pe	METAC	TAL	ie cos.	VER					1 ☐ Ye	s 2 🗆	No 3□P	robably 4 Dun	known
Records	> 40 0	Completed by									24a. Was an			utopsy findings av	
Ä	0 - 0	mo									autopsy perform 1 ☐ Yes 2	ed2	death?	completion of cau : 2□ No	ise or
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to mexamined?	nedical			_		26. Place of De						
of V	Z ⊆ Q	2	1 PYes 2 No		Hospital: 1 ☐ Inpatie	nt 2 ERV	Dutpatien	t 3 DOA Other	4 Nursing	Home	5 🗌 Resider	nce 6	□Other (Spe	city)	
	ing P	on:		Pending	28a. Date of Injur (Month, Day	Y Year) 28b	Time of Injury	Work	?	28d.	Describe hor	w injury	occurred		
isio	Attending r death. actor: After	icat	E	nvestigation Could not be	28e. Place of Inju	unc. At homo	form ot-		es 2 No	201	postion /Str	001000	Alumbarar	ural Route Numbe	
Division	al or A s after il Diracid in by	Certification:	4 Homicide	determined	building, etc	(Specify)	iaiii, sti	set, factory, office			City or Town,		realinger of re	arai riodio riambe	or,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Co (Check only one) 2 Me	rtifying Phy dical Exam	/sician: To the best iner: On the basis of and manner sta	examination a	ge, death and/or inv	occurred at the time restigation, in my opi	e, date and place nion, death occ	ce, and courred at	due to the car the time, da	use(s) a te and p	ind manner a: place, and due	s stated. e to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of	certifie	_			29c. License			29	d. Date	signed (Mon	h Day, Year)	
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_			30. Name and address of p	18	.1 1	CHE	an u	15 BUME	Anve	-NT	11	abo	1150	-	
	Sta Registr		31. Date filed (Month, Day,	1 1 2	32. egistra	ar's Signature	A	enter							

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		_			,00.09%	ertificate of	Death			
	Physici	an	Decedent's Name (First, Middle, Last	")				2. Date of De Month	Day	3. Time of Death
	/Medic		Prasanth Michael					August		
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	th	4c. County	of Death
Ę			Fredrick Memorial	Hospital		Fredric	If Under Oakle		Fred	
	Funeral		5. Social Security Number 6. Se	X 7. Age (In	yrs. last birthday	Months Days	If Under 24 Hr Hours Mir	(Month, Da	th ly, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		17 Yrs.			Apr. 1.	2, 1988	New York
	land		10a. State 10b. County	100	c. City, Town or I	Location				10d. Inside City Limits
	Mary	ō	Maryland Montgomer	CV C	aithers	hura				1 ☐ Yes x ☐ No
	288 100	Directo	10e. Street and Number	<u>.y</u>	arthers	10f. Zip Code			10g. Citizen of V	What Country?
	death with the Maryland me 23s or 28s-f ehow rroust be notified at		7510 Boxberry Terr	race		20879			USA	
	me 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13	. Was Decedent of H	lispanic Origin? (Specify Yes or No		e - American Indian,
	or Ita		1 XNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No				no Hican, etc.)		ck, White, etc.
3	hours after tural', or ite	٩	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	Indian
212-0030	J within 72 hours after death with the Marylan jiene. iiene. t'than "netural", or Itame 23e or 28e-f ehow than Medical Examinat neist be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dec	edent's Usual Occup e kind of work done	ation during most of w	orkina	16b. Kind of Bu	usiness/Industry
7	within 72 ene. than "ne he Medic	npje	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)			
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>	ould Mer Marke	မ	Krupakar Paul Thac					Lakshmi	-	
Mar	12 should h and Me 7 is mark reumati		19a. Informant's Name/Relationship (7)		10	ling Address (Street			•	
	tem 27 tem 27 other tr		Krupakar P. Thadik			Boxberry	Terrace	Date		City or Town, State
ō	of of or	1	1 X Burial 2 ☐ Cremation 3 ☐ I	Domousi from State	cemetery, cr	ematory or other pla				ck, Maryland
Baltimore,	nit. Peg entment ortent: Injury c		4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Service Ligen)			ret Cemete				
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			shock for heart failure. List only of					ac or respiratory a	rrest.	Approximate
		(i)		one 🗯 se on each line.		intel the mode of dyl	ig, such as cardi	ac or respiratory a	rrest,	Interval Between Onset and Death
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State Registrar

30. Name and address of person who completed cause of death (Item 23a

31. Date filed (Month, Day, Year)

32. Registrar's Signature AUG 2 5 2005

H. Sparke

111 Penn Street, Baltimore, Maryland 21201

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mantal Hydiana 2005

ysician		. Decedent's Name (First, Middle, L	.ast)					2. Date of Deal		V-	3. Time of Death
ledical		JOHN W	TRU	E, JR.				Month AUGUST	7	Year 2005	1:30 P
aminer		a. Facility Name (If not institution, gi				ity, Town, or Location	of Death		4c. C	County of Death	1
		SECOND CHANC				RINGDALE				NCE GI	eorge's
eral ctor		5. Social Security Number 6. 219–25–3335 Usual Residence of Decedent	Sex 7. Age	9 (In yrs. last bi	Yrs. If Uni Month	der 1 Year If Under ns Days Hours		8. Date of Birth (Month, Day, 12/14/.	Year)	9. Birth Con Mary	nplace (State or Fore untry) Land
H L	-	0a. State 10b. County		,	wn or Location			-			10d. Inside City Limi
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Tof	2	John Wayne True,						ores He			
raum		19a. Informant's Name/Relationship				ess (Street and Num.					ip Code)
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TO ME

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State of Maryland / Department of Health and Mental Hydiene 2.005

			1 - For State Registrar	State of	Maryland /		tificate of	Death		ene Z (105	2/951
	Physici /Medi		1. Decedent's Name <i>(First, Middle, La</i> Arle:		eth Tich	nell			2. Date of Death Month Augusi	Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, gire	re street and numb	oer)		4b. City, Town, o	or Location of Death	1	4c. County		
-			SunBridge Care (E1kton			Cec		
	Funeral Director		220-20-9007	Sex 7. I□M 2 💢 F	Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 7,	^{Year)} 1930	9. Birthp Cour Mar	elace (State or Foreign etry) yland
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c c	BAITIMORE, IMARYIGANG Z1Z13-UU35 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or thems 23a or 28a-1 show any injury or other traumatic event. It is Medical Examinating mortilis of an once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ∭No		Vas Decedent of H Yes, specify Cub. ☐ Yes 2][No	city Yes or No- Rican, etc.)		ce - Americ ck, White, y: Wh		
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	Man d 2 st th an th an traur traur		19a. Informant's Name/Relationship of Sharon J. Knox/I					and Number or Rural				
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	nit. Pages artment of ortant: If ii injury or o		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Continuity)	<i>'y</i>)	410	n Cen	netery	200	t 22, 5	Union,	Mary	land
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, , ,	IS, F.	y Ph	Part II. Other significant conditions	contributing to deat	th but not resulting	in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use cont	ribute to th	e cause of death?
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	II NECOFO The law requir sate has been si page 2 should	Completed							24a. Was an autopsy perform	ed?	Were autoporior to condeath?	psy findings available apletion of cause of 2 No
1	VICAL P siclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	lle2-1				26. Place of Death	(Check only one)		
	hys his ldii	- To	1 ☐ Yes 2 💢 No 27. Manner of Death		atient 2 ER/O	-		4 Nursing Hom)
	ding f h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	Time of Injury	28c. Injur Wor M 1	yat 25 k? Yes 2 ∐ No	3d. Describe hov	v injury occurr	ed	
	LIVISION I or Attending after death. Director: After the fune	ficat	3 ☐ Suicide 6 ☐ Could not b	e Jac Place of	Injury - At home, f	arm, stre			3f. Location (Stre	eet and Numb	er or Rural	Route Number
č	Ltal or A	Certification;	4 Homicide determined	building	, etc. (Specify)	, 5.10	ot, tadory, omoo		City or Town,	State)	or or rigital	riodia Number,
	To the Hospital or Attending Prowin 24 hours after death. To the Funeral Director. After transcompletely filled in by the funeral	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	ysician: To the be niner: On the basi and manner	s of examination a	ge, death nd/or inv	occurred at the tinestigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, dat	ise(s) and ma e and place,	inner as sta and due to	ated. the cause(s)
	To ti Withii To ti	Σ	29b. Signature and title of certifier				29c. Licens		290	d. Date signed	(Month, E	Day, Year)
	2.		Jarkas,	MD			DI	5314	9	regust	22,7	2005
	K		30. Name and address of person who	completed cause	of death (Item 23a)	(Type, F	rint)	a /	,	1	_	
			If Farkes	1 5-6	usons/	Ny	Thern	Che sep	ecke /	tospic	e [/	(Ton, 170
	Sta Registr		AUG 2 4 20	05 Here	istrai s Signature	CHOS!	35	•		,		2005 Uten, 19
			AUU A I	-								

Geraldine F. Titchenell Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple

			1-	For State Registrar		State of M	aryland /		artment of F rtificate of			lental H	ygien Reg. N		03	21931
			1. 0	Decedent's Name	(First, Middle, La	ist)						2. Date of D	eath			3. Time of Death
	Physici			GERALD	INE F.	TITCHE	ENELL					Month 08	0.4	ay ax	Year 205	7:054
	/Medio Examir		_			re street and number)			4b. City, Town, o	r Location	on of Death	00		c. County		
1	-Admin			L'TONS M	ANOR NUR	SING HOME			CUMBERI	LANI)			ALLI	EGANY	r
	Funeral		_	Social Security N			e (In yrs. last i	birthday)	If Under 1 Year	If Und	der 24 Hrs.	8. Date of B	irth		9. Birthp	place (State or Foreign
	Director			236-48-	9488	1□M 2XIF	73	Yrs.	Months Days	Hou	rs Min.	(Month, L AUG.	28, Yea 28, 1	931	WEST	VIRGINIA
	D D		_	ual Residence of	Decedent		·									
	how	_	10a	I. State	10b. County		10c. City, To								1	Od. Inside City Limits
	a-fs	Director		MD	ALLEG	ANY	RAW	LING	S							1 ☐ Yes 2 🛣 No
	57.28	ire	10e	. Street and Nun	nber				10f. Zip Code				10g. C	itizen of V	Vhat Cour	ıtry?
	th wi	<u>a</u>		21119 M	CMULLEN	HIGHWAY			2155	7			U	.S.A.	•	
	72 hours after deeth with the Maryland natural', or iteme 23a or 28a-f show dical Evariner must be rediffed at	Funeral	11.	Marital Status		12. Was Decedent Armed Forces?	Evar in U.S.	13. \	Was Decedent of H f Yes, specify Cuba	lispanic an Mexi	Origin? (Spe	ecify Yes or N	lo-		e - Americ	can Indian,
9	afta or it	F	1	_	ed 2 Married	1 ☐ Yes 2 ☐ If Yes, Give			1 ☐ Yes 2X No	Spec		,,				oic.
5-0036	ours iral',	d by		3 Widowed	4 XDivorced	Year or Dates:					y.			Specify	WHI	TE
5-(72 h 'natu	Completed		(Speci	15. Decedent's E ify only highest gr	ducation ade completed)	16	(Give	dent's Usual Occup kind of work done	durina n	nost of work	ing	16b.	Kind of Bu	isiness/Ind	dustry
2121	within ena. than "	ldu	Е	Elementary/Seco	ndary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d)						
2	filad w Hygien sther tl			10				HO	MEMAKER					HOME		
Ē	should ba filad withir and Mantal Hygiena. is marked other than aumatic event, tha Ma	Be	17.		First, Middle, Last							(First, Middl			ie)	
3	should ba nd Mantal marked c	2				WITT					OLDIE	PEAR		AVIS		
Maryland	s 1 and 2 should ba fliad within 72 hours aftar deeth with the Marylan f Haalth and Mantal Hygiena. them "natural", or iteme 23s or 28s-f show titem 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, The Medical Examinar must be notified at		198		ime/Relationship (ng Address (Street							· ·
	and laalit m 27 her t		_		NENE UPD	IKE / DAUC			8 E. WILS	SON	The second		_			21555
9	t of H t of H if iter or oth		20a	i. Method of Disp 1 🔀 Burial 2 [Removal from State	como	tery, crer	sition (Name of natory or other plac	ce)		Date	20c. l	_ocation -	City or To	wn, State
Ē	Pag man ant: ury				5 ☐ Other (Special			AWN	MEML.GARI	DENS	08/19	9/2005		LAVA	ALE,	MD
Baltimore,	parmit. Pages 1 and 2 Dapartmant of Haalth s Important: if item 27 it any injury or other tra once.		21.	Signature of Fu	neral Service Lice	nsee (/	,	22	. Name and Addre UPCHURCI			HONE.	DΔ			
ш	205 2			CHO!	nor II	· Upch	wech		202 GREI						MD	21502
			23	 a. Part1. Enter the shock, or hear 	ne di se ase, or com nt failure. List only	plications that caused one cause on each li	tha death. D	o not ent	er the mode of dyin	ng, such	as cardiac o	or respiratory	arrest,			Approximate Interval Between
	Physician		dis	mediate Cause (Final n	End 5	age	cliv	ronic C	bst	nuch	re L	une	-dis-	Euca	Onset and Death
	/Medical		res	sulting in death)	(Due to (or as	a consequenc	e of):					-0			C With the
	Examiner		Sec	quentially list cor	nditions.	b					_					
	ש ב	Examiner	cau	ny, leading to imuse. Enter Under use (Disease or i	rlying	Due to (or as	a consequenc	e of):								
	acuta ind trans	am	tha	it initiated events		c										
0,	a axe		163	ulting in death) L	alst	Due to (or as	a consequenc	e of):								
68760,	ficata ba axecutad g physician and ts the burial-transit	edical				d										
-	- 70 2		IF	FEMALE:												
Вох	eath cartif attanding for usa a	an/		b. Was decedent in the past 12		23c. If yes, outcome 1 ☐ Live birth		th 3	Ectopic pregnancy	,				23d. Date Mor	e of delive	ory Day Year
	a des	sic		1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5 🗆	Other (specify)					IVIOI	141	Day 16a1
P.0	Tha law raquiras that tha death carti ata has baan signad by tha attanding paga 2 should be datachad for usa a	Physiclan/M	-		ioont conditions			i- ab				20- Did	4-6		N . 4 - 4 - 4	
Ś	ras tha signad be dat	by	rai	t II. Other signifi	icani conditions	contributing to death b	ut not resulting	ın the ur	nderlying cause giv	en in Pa	ιπ 1.				3 Prob	e cause of death?
oro	w raquira baan siç should b	Completed					-						Yes 2	Z LI NO	3 Frob	ably 4XUnknown
e C	a law has b ya 2 st	ple										24a. Wa auto				psy findings available appletion of cause of
E		NO.										perf 1 ☐ Yes	ormed?	d	eath?	25 No
of Vital Records,	Physician: Tha this cartificata hiral diractor, paga	Be (25.	Was case referr	red to medical					26. PI	ace of Death	(Check only	one)			
1	nysio	2		1 Yes 2	No	Hospital: 1 Inpatie	ent 2 ER/C	Dutpatien	t 3 DOA Oth	er: 47	Nursing Ho	me 5 🗆 Res	idence	6 Othe	er (Specify	")
	ding Ph h. Aftar th funaral			Manner of Death	n 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b y Year)	. Time of Injury	28c. Injun Worl	y at k?		28d. Describe	how inju	iry occurre	ed	
9	Attending ir daath. ector: Aftai by tha funa	atle		2 Accident	investigatio				M 1	Yes 2	□No					
Division	i or Attsndi aftar daath. Director: A I in by tha fu	Certification;		3 Suicide 4 Homicide	6 □ Could not b determined	28e. Place of Inj	ury - At home, c. (Specify)	farm, str	eet, factory, office			28f. Location City or To	(Street a	nd Numbe 'e)	er or Rura	l Route Number,
	ital c					<u> </u>					- 4					
	Hosp 4 hou une aly fill	Medical	298	a. Certifier (Check only	1 Certifying Pi	nysician: To the best miner: On the basis o	of my knowled	ge, death	occurred at the tin	ne, date	and place, a	and due to the	cause(s	s) and mar	nner as st	ated.
	the hin 24	ledi		one)		and manner st	ated.									
	To the Hospitel or A within 24 hours aftar To the Funerel Direct complately filled in by	2	29t	. Signature and	title of certifier	0.00 .		2	29c. Licenso	e numbe	er -		29d. Da	-		Day, Year)
•	3			1 w	ment	my comment	. ří	.D.	Doo	55	32	Ó	A	ug 1	7, 2	.005
	This		30.	Name and addre	ess of person who	completed cause of	leath (Item 23a) (Type,						-		
	//10-		N	10050	CK S	his Mi	J, 48	10	ron le	ma	ce; tr	dtzo	ura	m	ID	21532
	Sta		31.	Date filed (Mont		32. Registr	ar's Signature	best	e e		,)			
	Registr	ar		AUG	T 9 YOON	JASEL -	19									

State of Maryland / Department of Health and Mental Hygiene 005 27952 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Rose M. Taylor Ам August 2005 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health Center <u>Annapolis</u> Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 🗓 F (Month, Day, Year) 11/28/1917 Director 201-50-6237 87 Pennsylvania Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other treumatic event, the Madical Examiner must be notified at Director Y Yes 2 No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'neturel', or items 23a 1923 Harcourt Avenue 21114 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or item any injury or other treumetic event, the Medical Examples. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Camillo Zaccarino Beatrice Pelino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Krezanosky/ Daughter 1923 Harcourt Avenue Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Venice Cemetery 08/08/2005 Cecil, Pennsylvania 21. Signature of Funeral Service License 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) month /Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown 충 signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably Be Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other Certification: To 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation 1 🗌 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerei filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID. 51169 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4201 Mitchellville Rd, #102, Bowie, MO 20716 Bringman, MD 31. Date filed (Month, Day, egistrar's Signature State AUG 0 8 Registrar

Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!", or items 23e or 28e-f ehow any injury or other treumatic event, the Medical Examinant centified at one of the contract of the medical Examinant Centified at one of the contract of the medical Examinant Centified at one of the contract of t	410-80-7496 Usual Residence of Decedent 10a. State 10b. County	ve street and number) Ty Hospital Sex 7. Age (In yrs. last birt.	Lanhan	or Location of Death	2. Date of Dea Month August	Day	3. Time of Death 3.005 5:32 PM
Examiner Funeral Director	Doctors Communit 5. Social Security Number 6. 410-80-7496 Usual Residence of Decedent 10a. State 10b. County Maryland Prince	Sex 7. Age (In yrs. last birt. 52	Lanhari		2105000		
ector	5. Social Security Number 6. 410-80-7496 Usual Residence of Decedent 10a. State 10b. County Maryland Prince	Sex 7. Age (In yrs. last birt. 1⊠ M 2□ F 52	hday) If Under 1 Year	3		4c. County o	f Death
ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	1⊠M 2□F 52 N	Months Dave			Princ	e George's
	Usual Residence of Decedent 10a. State 10b. County Maryland Prince			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)
ineral Director	10a. State 10b. County Maryland Prince	10c. City, Town			June 1	8, 1953A	lexandria, IL
ineral Director			or Location				10d. Inside City Limits
ınerai Dire	10e. Street and Number	George's Greent	oelt				1X☐Yes 2☐No
inerai	4-44		10f. Zip Code			10g. Citizen of Wh	nat Country?
Ine	6986 Hanover Par		207			USA	
-	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1975-	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
byF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 X Yes 2 No 1973— If Yes, Give Year or Dates: 1976	1 ☐ Yes 2√2 No	Specify:		Specify:	White
ted	15. Decedent's E		Decedent's Usual Occup	ation		16b. Kind of Busi	
pie	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working)	ng	TOD. KING OF BUSI	nessmoustry
Completed	12		Manager			Long Joh	n Silver
Be (17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle,	Maiden Sumame)	
ို	Paul Van Meter			Betty L			
	19a. Informant's Name/Relationship	Type, Print) 19b.	Mailing Address (Street	and Number or Rura	i Route Numbe	r, City or Town, St	ate, Zip Code)
	Shirley Dearolp		86 Hanover				
	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 [Removal from State cemetery	Disposition (Name of v, crematory or other place	(8)		20c. Location - Ci	•
	4 Donation 5 Other (Speci						lle, Maryland
	21. Signatur of Fureral Service Lice		22. Name and Addres				
	23a Part 1 Finter the disease or com	pligations hat caused the death. Do no	4739 Balti				MD 20781 Approximate
Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of	f):	cular Dis	seasē		
<u>a</u>		Due to (or as a consequence of	1):				
Pnysician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	,
by P	Part II. Other significant conditions	ontributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tot	pacco use contribu	ute to the cause of death?
					1 □ Ye	es 2 □ No 3 [□ Probably 4 Dunknown
Completed					24a. Was a		re autopsy findings available
é					autops perform	y prio ned? dea	r to completion of cause of
Re	25. Was case referred to medical		===	26. Place of Death			Ago S INO
2	e x rminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 XER/Outp	patient 3 DOA Othe	_		nce 6 Other	(Specify)
	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. Tir	ury Work			w injury occurred	unk
Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	8-14-05 5200	a P _M 1□	res 2 No			
it.	4 ☐ Hornicide determined	building, etc. (Specify)	n, street, factory, office	2	9f. Location (St. City or Town	reet and Number of State) 6986	Hanoyer Freenbelt, Md
	29a. Certifier 1 ☐ Certifying Ph	Scene		Pa	rkway,	pt#100 G	reenbelt, Md
edicai	(Check only one) 27 Medical Exam	ysician: To the best of my knowledge, niner: On the basis of examination and/ and manner stated.	death occurred at the tim for investigation, in my op	e, date and place, a pinion, death occurre	nd due to the ca d at the time, da	iuse(s) and manne ite and place, and	er as stated. due to the cause(s)
Me	29b. Signature and title of certifier	and manage	29c. License			9d. Date signed (A	
	QUED			.M.E.		ugust 15	
	30 Name and address of parces ::to	completed cause of death (Item 23a) (To		• # 1 • # 1	A	ugust I)	, 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month WILLIAM LAMBERT WHITE 2005 16:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year)
Months Days Hours Min. Jan. 11, 1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1☐M 2☐F 214-46-5948 49 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23s or 28s-f show The Medical Examiner must be notified at Maryland Harford Bel Air 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 634 Derringer Drive 21015 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) psychologist health care other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William H. White Betty Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother Betty White 18424 Woodside Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Aug. 16, 2005 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Maryland 21740 fred L. Vistal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events unto (or as a consequence of Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical TE FEMALE 23c. tf yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) I Yes 2 □ No 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 → TO 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page After this certificate 25. Was case referred to medical examiner?

1 Yes 2 100 Be 26. Place of Death (Check only one) Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 스 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To tha Funaral Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print) TH-12 W 11110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1- State Registrar Amend Item 4c per Dr., G847, Ogland Ostable Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Month **Physician** Leona Moon Lawrence August 9, Waytes 7:30 a M /Medical 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park, Md. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. B. Date of Birth (Month, Day, Year) Dec. 1, 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1√2 M 2□F Virginia 577-58-4153 61 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 1218 Perry Street N.E. #201 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 AMarried Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Government Mailroom Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Waytes Allene Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Waytes / Wife 1218 Perry Street N.E. #201 Washington, D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Washington NationalAug. 15, 2005Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Coensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes. P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Das Due to (or as a consequence of): stecem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Examiner Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Thipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

physician and the burial-transit The law requires that the death certificate be executed Box 68760 Records, P.O. Division of Vital death.

Funeral

Director

r than "natural", or Items 23e or 28e-f show the Medical Examiner must be mutified at

Hygiene. other than "

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: If item 27 Ia marked other tha any injury or other treumatic event, ITe I once.

Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

After the funeral of To the Hospital or Attending Director: hours after within 24 hours a

11N-8

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1610 CARROLL AVE, STE 340, THEOMA PARK, MD 2091 KARIM,

31. Date filed (Month, Day, Year) AUG 1 2 2005

29a. Certifier

Medical

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 005

27956 Certificate of Death Reg. No. 2. Dete of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 8:45 pm August Benjamin Watts /Medical 4b. City. Town, or Locetion of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner PINE VIEW NURSING HOME PRINCE GEORGE'S 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year 6. Sex **Funeral** Days Hours Months 1⊠M 2□ F Yrs 579-52-8640 65 July 25, 1940 Washington, DC Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f shov th and Mental Hygiene. 7 is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Directo DC Washington, DC 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1521 20002 Be Completed by Funeral T. STREET N. W. U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 1 1 1 2 1 2 □ N 1 9 5 6 − If Yes, Give Year or Dates: 1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔯 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) CAR SALESMAN 2 yrs PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) BOYD BENJAMIN WATTS **EVELYN** 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20710 permit. Pages 1 and 2 Department of Health a important: If item 27 is any Injury or other trai 4202 58th Ave. # 203 Bladensburg, Maryland THELMA J. WATTS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, CREMATORY 8/12/05 RIVERDALE, MARYLAND 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility JOHNSON * JENKINS FUNERAL HOME 716 KENNEDY STREET N.W. WASHINGTON, DC 20011 23a. Part1. Enter the diseast, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** C CALDIOVASCULAR Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Physiclan/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of): attending physician and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco uee contribute to the cause of death? director, page 2 should be datached 1 Yes 2 No 3 Probably 4 Unknown been signed Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 212 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Injun 1 Naturel 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation neral Director: A fillad in by the fu 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completaly (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier son who completed cause of deeth (Item 23a) (Type, Print) IVa 12070 e WISONSIC 31. Date filed (Month, Day, Year) AUG 1 2 20 32. Registrar's Signature State 2005 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiere 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month SIMEON WRIGHT SR. 2005 7:37P August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 508W. Deer Park Drive Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr. 17, 1937 **Funeral** 9. Birthplace (State or Foreign Months Days 1₽M 2□F Yrs. 474-13-0240 68 Director Liberia Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28e-1 show Director 1 ☐ Yes 2 ☐ No MD Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 503W. Deer Park Drive 20877 U.S.A. Completed by Funeral Items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other treumetic event, the Madical Examiner filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) Utility Worker Dulles Airport permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other treumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wright Liticia Taylor Clement A. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hawa F. Wright - Wife 508W. Deer Park Dr Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/20/05 ` 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Gate of Heaven 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature of Funeral Service Licens 246 N. Washington St Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Esophageal Cancer 6 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of). Tany, leading to immedia cause. Enter Underlying Cause (Disease or injury burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 XNo 3 TProbably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes Х☐ No autopsy performed? res 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 9 1 ☐ Yes XXNo 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after de-•al Director: Atte Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ATo the 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D0061083 August 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thambi, M.D. 14808 Physicians Ln Rockville, MD 20850 31. Date filed (Month, Day, Year) State AUG 11 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23a, b per doc 2848 10-17-05 vt.

State of Maryland / Department of Health and Mental Hygien 2005

State Registrar Amended #7 per/fh 08-16-2005 Certificate of Death cnm Rea. No. 2. Date of Death 3. Time of Death Month 11^{Day} , 2005^{ea} 12:15 P M **Physician** HESTER ELIZABETH FULLER WILKIE August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 6819 Running Springs Court 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Yrs. 92 241-10-9473 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County or 28a-f show the Medical Examiner nant be notified at 1 Tyes 2 No Frederick Frederick Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21703 U.S.A. 6819 Running Springs Court or Itama 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Packaging Belmont Hosiery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H ant; If itam 27 Is marked oth Margaret Sutton Charles Thomas Fuller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6819 Running Springs Court, Frederick, MD 21703 Ronald Perry (Son) permit. Pages 1 and 1 Department of Health Important: If itam 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gaston Memorial Park 8/14/2005 Gastonia, NC * 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 of Funeral Servine Lig 1201 NORTH MARKET ST., FREDERICK, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Renal Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy atten for u Live birth 2 Fetal death Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown detach 5 signed b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 Yes 2 No 2 10 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2/210 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: injury at Work? 1_Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To tha Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 MD D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick 21702 Hemen shah Thomas Johnson DV, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005 27959 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year AUGUST 05,2005 MICHAEL GERALD WARNER 1100AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 106 SPEICHER DRIVE ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days Hours 1 X M 2 □ F Director 378 64 1666 47 Yrs. MICHIGAN Usual Residence of Decedent death with the Maryland 10a State 10h Count 10c. City, Town or Location rai", or itams 23s or 28a-f show Examiner out the rotified at 10d. Inside City Limits Director 1 X Yes 2 □ No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 106 SPEICHER DRIVE Funeral 21401 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 □ No If Aes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 B marked othar than "naturat", or Ital other traumatic evant. In Medical Excriment 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify: Specify:WHITE 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **MECHANIC** 12 0 HEATING AND A/C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT WARNER ၉ MARY POGLISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle D. Warner/ Daughter 302 Bland Drive, Indian Head, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 to 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any injury or ^¹ 4 □ Donation 5 □ Other (Specify) KALAS CREMATORY 8-9-05 EDGEWATER, MD. 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician INTRA-ORAL SHOTGUN WOUND disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 XYes 2 🗆 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 X Yes 2 ☐ No Certification: To 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending Paul 8:30 th 1 ☐ Yes 2 ☐ No 2 Accident investigation FOUNT 8/5/05 in by the SUBJECT SHOT SELF Diractor: 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funaral C WOODED AREA 106 SPEICHER DR. ANNAPOLIS, MD. 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 6, 2005 O.C.M.E. person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 31. Date filed (Moi gistrar's Signature State 0 2005 Registrar

			1109104 GI	ate of Death	ental Hygier Reg. P 2. Date of Death	
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) GENEVA MCCORMICK WOODALL 4a. Facility Name (If not institution, give street and number) 4b. C		August	18 2005 5:15p M 4c. County of Death
	Funeral Director			hs Days Hours Min.	B. Date of Birth (Month, Pay, Yea Iar 14 1	Kent 9. Birthplace (State or Foreign Country) West Virgini
	פ	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Kent Galena			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28s	ai Direc	31465 Jim Davis Rd.	Zip Code 21635	U	Citizen of What Country? J.S.A.
980	n 72 hours after death with the Maryland "natural", or itams 23a or 28a-f show adical Examiner nust be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Ye Year or Dates:	ecedent of Hispanic Origin? (Speci specify Cuban, Mexican, Puerto Ri s 2		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 ho piene. r than "natur the Medical	ompieted	Flementary/Secondary (0-12) College (1-4or 5+)	Jsual Occupation I work done during most of working T use retired) ria Worker	l l	Kind of Business/Industry nt County Board Education
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) Maywood McCormick	18. Mother's Name (Edith N	icholas	
Baltimore, Mar	of Health of Health litem 27		, , ,	or other place)	Galen te 20c.	a, MD. 21635 Location - City or Town, State myrna, DE.
Baltin	permit. Page Department: importent: if any injury o		21. Signature of Juneral Sarvice Consess 22. Nam. Gale:	West Cross St	me of S . Galen	tephen L. Schaec a, MD. 21635
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nponade		Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
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rds, P.O	equires that the second of the second of the detaction of the detaction of the second	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying Congostive Nouve to love	ng cause given in Part f.	23e. Did tobacce 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Reco	The law ate has b page 2 sl	Complet	Diabotos mollitus		24a. Was an autopsy performed?	
f Vita	Physician: The this certificate ral director, page	To Be		26. Place of Death (IDOA Other: 4 Nursing Home		6 ☐Other (Specify)
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28a. Date of Injury (Month, Day Year) (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, street, fact building, etc. (Specify)	Work? 1 □ Yes 2 □ No	d. Describe how in if. Location (Street: City or Town, Sta	and Number or Rural Route Number,
Ö	Hospitel or 24 hours afte Funerel Dire tely filled in t	Medical Cert	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigal		d due to the cause	(s) and manner as stated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier.	29c. License number	29d. C	Date signed (Month, Day, Year)
_	10		20 Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Donaher, M.D. 119 C. North	Main St. Gal	ena, MD	. 21635
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 5 2005 32. Registrar's Signature	0		
DHI	MH 17 Rev 1/2	001	ORIGINAL			

State of Maryland / Department of Health and Mental Hygienen For State Registrar Certificate of Death Rag. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10:39 A M Elsie Leona Watson 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 727 Bedford Street Cumberland Allegany 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 1□ M 2□ F 1929 Director May 11 218-24-7862 76 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or Items 23a or 28a-f show try or other transmit or Annual to a North traumatic event, Ite Modical Esterill er may be notified at 10a State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show the profitted at 10d. Inside City Limits MD Allegany Cumberland Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 727 Bedford Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 □ Widowed 4 □ Divorced if Health and Mental Hygiene. item 27 is marked other then "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Psychiatric Aide Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter R. Gordon ٩ Virginia B. (Imes) Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meissa Clayton granddaug 727 Bedford Street Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Scarpelli Funeral Home, PA 8/2/2005 ` 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown MD 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARCINOMA UF COLON METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physiclan/Medical Examiner day, leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsecuence of). Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2. No. 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.

I Director: After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo 23371 2-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar Zaman M.D. 625 Kent Avenue Cumberland MD 21502 32. Redistrar's Signature State AUG 0 4 2005 Registrar

			For State	State of Maryland	d / Depa	artment of H	ealth and M	Mental Hyg	ien ⊉ () (15	27962
			Registrative IVE #Special Registrative Regis		Cei	rtificate of L	Jeath	2. Date of Deat	g. No.		3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)					Month August		Year	10:50am ^M
	/Medic	al	George	Wheeler		4h Cihi Tourn or	Location of Death		4c. County		10.Joani
	Examin	er	4a. Facility Name (If not institution, give : 8100 Connecticut			Chevy			Montg		
	Function		5. Social Security Number 3214 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			
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	with t		10e. Street and Number	Arramus		20815		'			•
	death with the Maryland ma 23a or 28a-f ahow r must be notified at	Funeral	8100 Connecticut	12. Was Decedent Ever in U.	S. 13.			pecify Yes or No-	United	a Sta	
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N	filed within 72 Hygiene. other than "natent, Ine Medic		17. Father's Name (First, Middle, Last)		11000	I Owner a		ne (First, Middle, M			У
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Maryiand	should be and Mental a marked o	To	19a. Informant's Name/Relationship (Ty		19b. Mailii	ng Address (Street a				State, Zip	Code)
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ē,	K Hear		20a. Method of Disposition	20b. P		osition (Name of matory or other place			20c. Location -		own, Stete
Baltimore,	permit. Pages Department of H Important: If ite any injur or of		1 ☑Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	endly			3/2005	Charles	ton,	S.C.
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			23a. Part1/Enter the disease, or compi sheck, or heart failure. List only or	cations that caused the feath re cause on each line.	n. Do not en	ter the mode ot dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
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8760	death certificate be executed e attending physician and nd for use as the burial-transit	dical		J							
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g Q	uires sign id be	d by						1 □ Ye	s 2 🕅 No	3 🗆 Prot	pably 4 Unknown
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⋝	Physici this cer al direc	To B	examiner? 1 🗆 Yes 2 No	Hospital: 1 🗆 Inpatient 2 🗆	ER/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nursing H	ome 5 🕅 Reside	ence 6 Oth	ner (Specif	<i>'y)</i>
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<u>S</u>	uttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	201 1 1 (0)			10
Division of Vital Records,	or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, tactory, office		City or Town	reet and Numb n, State)	er or Hurz	al Route Number,
_	spital ours s reral l		29a. Certifier 1 X Certifying Phy	sician: To the best of my kno	wledge, deat	h occurred at the time	ne, date and place	, and due to the c	ause(s) and m	anner as s	tated.
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exami	ner: On the basis of examiner and manner stated.	tion and/or in	vestigation, in my of	pinion, death occu	rred at the time, d	ate and place,	and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie		1	29c. License		2	9d. Date signe		•
	15		mr. (grille D	/	D394	56		Augus	t 9,	2005
			30. Name and address of person who co								
			Dr. Lila McConnell			enue, #14	00 Chevy	Chase,	MD 2081	1.5	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signa	lure A	make I					

State of Maryland / Department of Health and Mental Hygien 0 0 5

Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 Year **Physician** 05:30 M AUG. WILHOIT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner QUEEN ANNE **CENTREVILLE** 310 N. LIBERTY ST. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K 5,1942 MARYLAND Director 212-40-7704 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Worle rediffed at 1X Yes 2 □ No Director CENTREVILLE **QUEEN ANNE** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23s or other results or **USA** 21617 310 N. LIBERTY ST. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and it item 27 is marked other than "natural", or Itel ury or other than taumatic event, Its Musical Exactionary or other traumatic event, Its Musical Exactional 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 ₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD SERVICE UNKNOWN UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 300 DEL RHODES AVENUE, QUEENSTOWN, MD 21658 SHARON LOVING/ SOCIAL WORKER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State STEVENSVILLE CEMETERY 8-5-2005 STEVENSVILLE, MD permit. Page Department Important: I any injury o once. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License PELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 4 hknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be autopsy performed? page 25 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending To the mospine within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Exerminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2036 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) 2/08 Di Donnio Drue Cherle 50-

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG

8 2005 32. Segistrar's Signature

			Please I	State of Ma									27964
			1 - State Registrar			Cer	tificate	of Death		Re	g. No.		
	g.		1. Decedent's Name (First, Middle, Last)						ate of Death lonth	Day	Year	3. Time of Death
	Physicia /Medic			Marie I	lelen	Yunge	r		Aug	ust		.005	10:15a M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	wn, or Location of D	Death		4c. County		
			24041 Glade Valle		. // /	4	If Under 1 Y	Damascus Year If Under 24	Hrs a D	ate of Dieth		ntgor	
	Funeral		5. Social Security Number 6. Se	x //.Ago ⊒M 2⊠F	e (In yrs. las	Yrs.			Min. (N	ate of Birth fonth, Day			place (Stete or Foreign ntry)
	Director		388-05-7439 Usual Residence of Decedent		95				Maı	ch 8,	1910	W1S	consin
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						Od. Inside City Limits
	Man a-1 ah	ţo	Maryland Montgom	nerv	Dama	scus							1 ☐ Yes 2 ☑ No
	h the	Director	10e. Street and Number				10f. Zip Co	de		10	g. Citizen of	What Cou	ntry?
	72 hours after death with the Maryland natural', or itams 23a or 28a-f ahow Jigal Exandric in wat be natified at	aiD	24041 Glade Valley	y Terrace				20872			United		
	ams ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Deceden f Yes, specify	t of Hispanic Origin Cuban, Mexican, P	n? (Specify Y Puerto Rican	es or No- , etc.)		ce - Ameri ck, White,	ean Indian, etc.
ğ	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give	40		1□Yes 2፟፟⊠	No Specify:			Specif	y:	
5-0036	hours tural		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		16a Decer	ient's Usual C	occupation		1	6b. Kind of E		nite
7	- 1 3	Completed	(Specify only highest grad	fe completed)		(Give	kind of work of DO NOT use i	fone during most of	f working	'	00. 11810 01 2		
212	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Swit	chboar	d Operate	or		N. I.	н.	
ō		Be C	17. Father's Name (First, Middle, Last)							t, Middle, M	aiden Sumai	пе)	
<u>a</u>	ould be Mental arked o	To B	Thomas Tiedeman					Marga	ret We	ber			
Maryland	should Name	-	19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailir	g Address (S	treet and Number of	or Rural Rou	te Number,	City or Town	, State, Zip	Code)
Σ	and 2 alth a		Kitty Boone/ Daugl	nter		24041	_Glade	Valley '			mascus		
Ore	of He of Hitam		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 8	Removal from State	20b. Plac	ce of Dispo netery, cren	sition (Name natory or othe	of r place) 8/	Date 15/200		0c. Location	- City or T	own, State
Ĕ	Pag ment ant: I ury o		'4 □Donation 5 □ Other (Specify,		Metr	-		ematoriu	n Inc.	A	lexand	ria,	Virginia_
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other treumatic a <u>once</u> .		21. Signature of Funeral Service Licens	see	1	22	Name and A	Moleswo	rth P.	. A F1	uneral	Home	2
	205 20		Sode of	V-AM		2	6401 R	idge Road	d, Dam	ascus	. Mary	land	20872 Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ine cause on each li	the death. ne.	Do not ent	er the mode o	ronying, such as ca	ralac or resp	oratory arres	St,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	eim	mic							
	/Medical Examiner		resulting in dealin)	Due to (r as	a conseque	once of):	40	. 4 1 1	1				12 de 1 med
		<u></u>	Sequentially list conditions,	b	a conseque	nce of):) 11.	et ille	chan				nus mea
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										4 -
	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):	1100	<i>y</i>					
760	eath certilicate be executed attending physician and for use as the burial-transit	cail		d									~ ~
9	tificat ig phy as th	ledi											
Вох	h cer endin	an/N	23b. was decedent pregnape	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregi	nancy				ite of deliv	ery Day Year
	b deal	sici	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at 9☐Unknown	time of dea	ith 5□	Other (speci	ty)			141	Jilai	Day
P.0	The law requires that the death certificate ate has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	9 Unknown Part II. Other significant conditions co	estribution to don'th b	ut not rocult	ing in the u	adorhiag agus	o gwon in Part I		3e Did toha	acco use con	tribute to t	he cause of death?
	res tha signed be det	ρ	Partil. Other significant conditions co	dehil			idenying caus	se giveirii raitt.		1 □ Yes			pably 4 □Unknown
orc	w require been si should b	Completed		0 0 111 0	1 - 1				-			111	, dia dia anno il altra
Sec Sec	has by	npi								4a. Was an autopsy perform	ed? .	prior to co death?	ppsy findings available impletion of cause of
<u>~</u>	cate									☐ Yes 2	□N ₀	1 🗆 Yes	2 No
<u> </u>	ician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	Hospital:	205	D/O-4i	it 3 DOA	Othor	Death (Che		nce 6 🗆 Oth	(C	5-1
Division of Vital Records,	Attanding Physician: If death. actor: After this certificably the funeral director.	—	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 El	8b. Time of		Injury at Work?		V	v injury occur		у)
on	th. th. : Afte	tior	1 ZNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No					
VIS.	or Attano after death Diractor: in by the	ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At hom	ne, farm, str	eet, factory, o	ffice	28f. L	ocation (Stre	eet and Numi	ber or Rur	al Route Number,
ā	s after al Dirac	Certification:	4 Homicide	Duilding, et	c. (Specify)					,			
	To the Hospital or Atlanding Physician: The within 24 hours after death. To tha Funaral Director: After this certificate h completely filled in by the funeral director, page	edical (sician: To the best iner: On the basis o									
	the H in 24 tha F plete	ledi	one)	and manner sta	ated.								
ı.	To with	Σ	29b. Signature and title of certifier	1./14				icense number	77		d. Date signe		
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	4		30. Name and address of person who de Maryam Farazha M.					accure M-		4 2007	7.2		
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State of Maryland / Department of Health and Manta Hygiene 965 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year August 22 **Physician** 00:44A ,2005 Patricia Marie Bunting /Medical 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 ☐ M 2 ☐ F 193-32-6159 Yrs. Director April 25, 1942 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ∑Yes 2 No Md. Cecil E1kton Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21921 U.S.A. or Items 23a 120 Lafayette Drive death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 **₩**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygien 7 Is marked other th sales clerk retail food sales 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marie A. Weber Pastore James F. Pastore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any injury or other traun once. 120 Lafayette Drive, Elkton, MD 21921 Eugene F. Bunting/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) SS Peter & Paul Cem. | 8/27/2005 | Springfield, Pa. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Conset and Death
Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD Pnysician 12a15 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): attending physician of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifice ours after death.

erel Director: After this certificatiled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Oescribe how injury occurred 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Union 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

Sunting, Patricia Muie

State of Maryland / Department of Health and Mental Hygien 005 27966 1 - Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 8:40рм Frederick J. Bold Jr. 2005 /Medical 24 August 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore Country) | NewJersey 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2 F Director 151 20 8253 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or itsms 23a or 28a-f show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at Baltimore Essex 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 Virginia Ave. 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itsm 27 is marked other then "any Injury or other traumatic svent, II to Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Foreman 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick J. Bold Sr. Elsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond L. Ray /son 2148 Sagebrush Court Eldersburg MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State BayviewCrematory Baltimore MD 8/25/05 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home of Essex 21. Signature of Funeral Service Licenses onn 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer to limi METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No of Vital 1 Yes 1 ☐ Yes 2 ☐ No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSOICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Curs D58303 AUGUST 25 2005 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) ND 6601 N. Christes ST TOWSON MD 21204 AMON CHARLES Sparke 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar HALIN AUG 2 6 LUUS

DHMH 17 Rev 1/2001

old, Frederick 8-24-05

			1 - For State Registrar	State of Marylar	nd / Departm <i>Certific</i>	ent of Health ar	d Mental H	yg igne 05	27967
	Physici /Medio		Decedent's Name (First, Middle, Last)	BROWI	V		2. Date of D Month AUQU	Day Ye	
	Examin		4a Facility Name (If not institution, give	street and number)	457	oty, Town, or Location of E	Death	4c. County of E	
	Funeral Director		5. Social Security Number 6. Sec. 15	7. Age (In yrs.	last birthday) If U	nder 1 Year If Under 24 ths Days Hours	Hrs. 8. Date of B	irth (3/93)	Bithpolace (State or Edreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County	100-Ci	ty, Town or Location	<u> </u>	/		10d. Inside City Limits 1 → s 2 □ No
	with the last or 28a-	i Direct	10e. Street and Number	ROL	10f	71/2/3()		10g. Citizen of When	
"	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show the Medical Examina in the indiffed at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 ☐ No		ecedent of Hispanic Origin specify Cuban, Mexican, F	? (Specify Yes or Nuerto Rican, etc.)		merican Indian, hite, etc.
21215-0036	72 hours a natural', o Ical Exan	by	3	If Yes, Give Year or Dates:	16a. Decedent's	s 2 No Specify:		Specify:	O//C pss/Industry
2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Deparment of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exeminar must be maillised at any injury or other traumatic event, the Medical Exeminar must be maillised at any once.	Completed	Elementary Secondary (0-12)	College 1-4or 5+)	WAREH	work done during most of IT use retired SUPE	RUISOR	WAKEI	40USE
Maryland	should be fill and Mental His marked oth	To Be	17. Famer's Name (First, Middle Dest)	OWN		18. Mother's	Name (First, Middle	Nalden Symame)	
e, Mar	Health and tam 27 is mutant tam 27 is mutant tammother traum		19a, Informant's Name/Relationship (Ty	7NS (drughte	1807	ress (Street and Number of	1 14/13	A 160 MO	2/239
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 Denrial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	lace of Disposition (cemetery, cr. atory)	Name of or other place)	Date 3-31-05	GIAIGA'S	W- West M
Ba	permit Depar Impor any in		21. Signarula of Funeral Sarvice License	Bounde	22. Nam	e and Address of Facility	ASEPH AVE	BAILO	W 2302
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.		mode of dying, such as car	diac or respiratory :	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,		sullicien	СЧ			ayears
	and I-transit	Examiner	if any, leading to immediate Section 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or as a consection of the consection of					1 year
68760,	icate be executed physician and s the burial-transit	edicai E			(author of).				
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours alter death. On the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree of the second second second second second second second second second second second second second second second second second sec	il death 3 ⊟Ectopi	c pregnancy (specify)		23d. Date of Month	delivery Day Year
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ion	ath. r: After e funera	ation:	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fac y)	etory, office	28f. Location (City or To	(Street and Number or wn, State)	Rural Route Number,
	Hospi 24 hour Funar etely fill	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my known: On the basis of examina and manner stated.	owledge, death occur ition and/or investigat	red at the time, date and pition, in my opinion, death o	ace, and due to the ccurred at the time,	cause(s) and manner date and place, and o	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	nth, Day, Year)
,	~			of. 1 W.D		AT 24389	46	August, a	10th 2005
1	0 1		30. Name and address of person who con			ial Hospita	Cm, J		
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 2. 6. 201	32. Polistrar's Signa					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year BETTY JEAN BROWN-JACKSON AUGUST 2005 4:16 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 DORCESTER ROAD GLEN BURNIE ANNE ARUNDEL COUNTY If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 XF Yrs. Director 214-54-5640 57 28. 1947 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Directo Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Louise Terrace 21060 Items 23a USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _2 __No If Yes, Give __Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 🕅 No Specify. 3 ☐ Widowed 4 ☐ Divorced 'natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Feeder and Packer Box Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Harold Gladys Virginia Yingling Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Dorcester Rd., Glen Burnie, Md. (Son) George Jackson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. Glen Haven Mem. Pk. 8/27/2005 Glen Burnie, Maryland ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Ave., Balto., Md. 21. Signature of Euneral Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21225-1856 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician months /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Box 68760, Due to (or as a consequence of): physician Physician/Medicai as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed?
Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? 1 ☐ Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 4 \square Nursing Home 5 \square Residence 6 γ Other (Specify) d \circ t 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier The desired in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (4 completed cause of death (Item 23a) (Type) Print) 80Z8

State Registrar 31. Date filed (Month, Day,

6 2005

			For State Registrer	State of Marylar	nd / Department of F Certificate of		ntal Hygian	05 27	969
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	Funeral Director		5. Social Security Number 6. 9	7. Age (in yrs		If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year) 17/03/1921	9. Birthp Coun	lace (State or Foreign
	he Maryland 18e-f ehow ctiffed at	ector	MD BALTI		IKESVILLE		10-0		Od. Inside City Limits
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If eath and Mental Hygiene. Itiem 27 Is marked other then "naturel; or Items 23a or 28e-f show other treumetic event, Ite Medical Exter incurrent terrorified at	d by Funeral Director	10e. Street and Number 6812 PIMLICO DRI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	VE 12. Was Decedent Ever in the Armed Forces? 1 Yes, 2 No 1f Yes, Give Year or Dates:	J.S. 13. Was Decedent of If Yes, specify Cub	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:		U.S.A. 14. Race - Americ Black, White, Specify: WHIT	can Indian, etc.
21215-0036	filed within 72 h Hygiene. Ither then "natu ent, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire SALES	during most of working d)		CLOTHING	dustry
Maryland	should be filed nd Mental Hygi marked other umetic event, I	To Be	17. Father's Name (First, Middle, Last) JOSEPH 19a. Informant's Name/Relationship (7)	vpa. Print)	KAPLOWITZ 19b. Mailing Address (Street	18. Mother's Name (I ANNA and Number or Rural F		UNKNOW	
	es 1 and 2 sho of Health and f item 27 le ma r other treum		AMY PERLOW / DAU 20a. Method of Disposition	GHTER 20b.	9 DORSET HIL Place of Disposition (Name of cometery, crematory or other pla	L COURT - (OWINGS MI	LLS, MD 2	21117
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any injury or othe		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 2). Signature of uneral Service Lice	BE	TH JACOB 22. Name and Addre	08/25/ Poss of Facility SOL I ERSTOWN ROW	LEVINSON		INC.
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,0,	المشير	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. [Disease of k juny that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.)					
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Il Records,	isicien: The law requir s certificate has been si lirector, page 2 should I	Completed					24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of 2 No
ion of Vital	ting Phy n. After this funeral d	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Actural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Wo	ry at 28		6 Other (Specification occurred)	ν)
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	Medicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Examone) 29b. Signature and title of certifier	ysicies: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, death occurred at the tileation and/or investigation, in my death occurred at the tileation and/or investigation, in my death occurred at the tileation and or investigation.	opinion, death occurred	at the time, date at 29d. D	ate signed (Month,	Day, Year)
	σ_{j}		30. Name and address of person who	completed cause of death (Ite	7. D. KE	S-ØØØ	A	agust	24,2005 timere Mozro
	Sta Regist		31. Date filed (Month, Day, Year)	32. Rapistrar's Sign	nature Hopens F	10Spith 6	OU N WOLF	est ball	TIMES OU LES

DHMH 17 Rev 1/2001

SHELLEY BARNES UNK 05-05557 d1

the Maryland

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hyping 5 1. State Unpend Item 23a,27,28a-f per me Collin at Death tas Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Shelle 2005 5:40 P August 6. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 78-431 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits wast be notified at 1 XYes 2 □ No Directo MO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Heelth and Mental Hygiene 1 in the 1 item 27 is marked other then "natural", or items 23a or 2 any Injury or other traumatic event, the Modical Exerting the 100 and 10 10 ans 040 nDe Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes ≥ 2 ☐ No If Yes, Give / Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: ac 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) une inplayed 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ames miller ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) neice Valerie Murray-5041 Ave Frederick 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 05 Cemeter IrINITY 22 Name and Address of Facility 21. Signature of Funeral Service Licens Tome Parto ma . 2124 march renera Approximate Interval Between Onset and Death Part . Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm while Cause (Final disease or condition resulting in death) Physician Cocaine and alcohol intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 @Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No Certification: To To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury 8-16-05 28b. Time of unk 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred unk 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident found 6X Could not be 3 Suicide ^{28I.} Location (Street and Number or Rural Route Number. City or Town, State) **2102** Barclay Street Baltimore, Maryland Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide found in house 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME August 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day Your 111 Penn Street, Baltimore, MAryland 21201 filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 6 2005

Registrar DHMH 17 Rev 1/2001

or Attending Physician: The law requires thet the death certificate be executed

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death.

To the Hospital within 24 hours e To the Funerel C

Box 68760,

Division of Vital Records, P.O.

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			State Registrar Amend I Decedent's Name (First, Middle)	t <u>em #6 Per</u> ^{#e, Last)}	FH G848	3_10/4	4//0919/19/	Call	2. Date of Death	t Day	3. Time of Death
	Physici /Medic	_	Mary (NMN)	Boni					Cueyest	Day 23 Year 2005	1015 AM
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_	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. la	ast birthday)		If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Y		place (State or Foreign
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	/land		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	, Town or Lo	cation			1	Od. Inside City Limits
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "naturat", or items 23a or 28a-1 show any injury or othar traumatic evant, Its Maciteal Examinat must be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	rried 1 Tyes 2	es? ≧⊠No		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2☑ No	, Mexican, Puèrto Specify:	Rican, etc.)	Black, White, Specify:	etc.
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e, N	1 and Health am 27 thar tr		Chris Owens /	Executor	20b. Pl	ace of Dispo	sition (Name of	-	Towson,	Maryland 2	1204
γğ	Pages nent of int: if its iry or o		1 DBurial 2 Cremation 4 Donation 5 Other (tate Ce	metery, crer	natory or other place) on Cemete:)			
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or othar tra once.		21. Signature of Tuneral Service			-				arlington,	Maryland
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Vit;	Physician: this certific ral director,	o Be	25. Was case referred to medic examiner? Volves 2 □ No	Hospital:	patient 2□E	ER/Outpatien	Other		Check onl one	0 DOH 10 11	
ιof		n; To	27. Manner of Death	28a. Date of		28b. Time of Injury	28c. Injury a Work?		28d. Describe how	e 6 Other (Specify injury occurred	9
sior	Attanding ir death. ector: After by the funer	catlo		igation	Buy rousy	mary		es 2□No			
Division	al or Attandi s after death al Director: A ad in by the fu	Certification;		mined 286. Place o	f Injury - At hor g, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
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7	10		30. Name and address of person	Alter HILL	MAE of death (to-	23a) (Tuna	Print) °	T406	U	ugent 2	5,2005
	10		BERRHAD Y	Who completed cause	2018	1 HO	LABIRD	AVE	BALTO 1	W ziz	22
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State of Maryland / Department of Health and Mental Hygien 15 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:12P 2005 August 22, John Carson Bottomstone /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Air

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Harford 1823 Prindle Drive 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□F Months Jan. 31, 1918 Pennsylvania Director 213-07-4209 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "neturel", or Itams 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Harford Bel Air Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1823 Prindle Drive 21015 Funerai fited within 72 hours aftar death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturer 11 General Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fit Health and Mental H tem 27 le markad oth Amanda Grace **Hoffman** William Bottomstone, Sr. Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le eny injury or other treu once. 1823 Prindle Drive, Bel Air, Maryland 21015 Anna Bottomstone - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 1 3 Removal from State Timonium, Maryland Dulaney Valley Mem. 8/25/05 21. Signature of Edit 22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland 21014 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PHIMONARY Physician Embolism hours disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cenebrourscular Accident 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ₽ No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Certification: To 1 Yes 22 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number M. de la lant up Pit August 23, 2005 D14036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deive Brande VIEW 19/2501112 32. Begistrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 19 2005 Marie Buckner August 1601 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis Annapolics

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | May 25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral 1 ☐ M 2 🕱 F Virginia 1934 71 211-26-9135 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heath and Mental Hygiene.
and of Heath and Mental Hygiene.
and: If item 27 is marked other than "natural; or items 23a or 28e-f show uny or other traumatic event, ite Madical Equivalent constitution. 1 XYes 2 □ No Directo Mitchellville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TISA 20721 11516 Waesche Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗗 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Worker 12th yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Mc Cullough Sarah Rowe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 is any injury or other trains000. 11516 Waesche Dr. Mitchellville, Md. Valarie Holzer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial
Gardens 20a. Method of Disposition ₽ Burial 2 Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 8/25/05 Davidsonville, Md. 21. Signature of Funeral Service Licensee Name and Address of Facility M. Reese & Sons Mortuary, P.A. eese MOUY8 Annapolis, Md. 821 West St. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. as the b IF FFMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 🖾 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 PNo Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ ₩6 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Certification: Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by determined after 4 T Homicide within 24 hours a To the Funerel D 29a. Certifier 29d. Date signed (Month) Day, Year) 29b. Signature and title of certifie 2 address of person who completed cause of death (Item 23a) (Type, Pring 61107

State Registrar

31. Date filod (Month Day.

6 2005

32 Registrar's Signature

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			For State	State of Maryland /	-	rtificate of		wentar m			21914
			Registrar 1. Decedent's Name (First, Middle, Las	it)		imoute of	Death	2. Date of D			3. Time of Death
	Physici		Virgie M	lae Bro	~			A UCL -	20	ay Year	3:31AM
	/Medic Examin		4a. Facility Name (If not institution, give				or Location of Deat	-		c. County of Deat	
			Anne Annoted Me	dical Center		Annapo	zik		A	mne An	ndei
	Funeral		5. Social Security Number 6. S	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs	8. Date of B	irth		hplace (State or Foreign
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	r 28a	Director	10e. Street and Number	MIGET AIMA	ŲΟ.	10f. Zip Code			10g. C	itizen of What Co	untry?
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	r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of I If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White	rican Indian, e, etc.
3	s afte	by Fu	1 ☐ Never Married XXMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give		1 ∐ Yes 2 ဩKNo	Specify:			Specify: E	Black
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and	be filed ital Hygird of other event, t	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle			.,
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na	permit. Departi Import. any inj		1 1	10 MOOY83	8	Wm. Ree 21 West	se & So St. An	ns Mor napoli	tua;	KY, SiA	^ 1
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0	ath. pr: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □No				
Division of	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location City or To			ral Route Number,
	rel Di										
	Hosp 24 hou Fune fely fi	Medicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge niner: On the basis of examination a	ge, death and/or inv	n occurred at the til vestigation, in my o	me, date and place opinion, death occi	e, and due to the urred at the time	cause(s , date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this of completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Da	ate signed (Month	n, Day, Year)
	F≥F8		Much n &	mo		DO	060176			3-20-05	
	Λ		30. Name and address of person who	completed cause of death (Item 23a) (Type,		060116		ے	5-XU-CO	3
	(Micah R. Fishe	- Anne Anne			1 Center	Annup	vies	סורו	
	Sta		31. Date filed (Month, Day, Year) AUG 2 6 200	3 Registrar's Signature	1						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hander's Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2005 2:30 pM William E. Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis Sr. Residential Assisted Living Facility, Anne Arundel Annapolis Inc. 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** XOM 2□F Yrs. 3 Maryland Director 214-05-2444 Jan. 1918 Usuat Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location wode ir Items 23a or 28e-f ehov in er nust be notified at P⊡Ves 2 □ No Completed by Funeral Director Maryland Anne Arundel **Annapolis** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 1960 Forest Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1⊠Yes 2⊡No IfYes,Give Year or Dates: W.W.II 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 ö th and Mental Hygiene. 27 is marked other then "naturel", or treumetic event, the Medical Even. 3 ☑Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.M. Church <u>Minister</u> 12th 3yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary F. Plummer James T. Brown ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1960 Forest Dr. Annapolis, Md. 21401 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tree once. Pearl A. Green (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Hill Crest Cemetery 8/24/05 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 821 West St. Sons Mortuary, Annapolis, Md: H. Beese MOOY83 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final DEMENTIA Physician END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DISEASE 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: ours after death.

Nerel Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 \sum \text{Nursing Home} 5 \sum \text{Residence} \text{Softher (Specify)} \text{LIVING} Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUG 22, 2005 D57531 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Highway Millersville, MD 21108. 8601 Veterans
32. Registrar's Signature Mohit Nego 31. Date filed (Month, Day, Yea)

DHMH 17 Rev 1/2001

Registrar

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	1	_ State	State of Maryla	nd / Depa	artment of H tificate of L	ealth and M Death		eno ⊈ /)/(g.No.)
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/Medical Examiner Funeral		a. Facility Name (If not institution, give si	reet and number) Nedical C 7. Age (In yrs	といてER : last birthday)	4b. City, Town, or	Location of Death Line of Death Line of Death Line of Death	8. Date of Birth (Month, Day,	Year) Cot	place (State or Foreign
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parmit. Pages 1 ar permit. Pages 1 ar Department of Hea Important: if Item any Injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	- W	estern	Stor C	em, aug,		Baltimno eral Hom we 13 acti	
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death certific attending p d for use as	- ע	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of prec 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify)	<i>y</i>	2000	23d. Date of del Month	ivery Day Year
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F Signature	0 0	27. Manner of Death	iospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)		nt 3[] DOA		ome 5 Reside	ence 6 Other (Spe	cify)
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Hospi 4 hou Funer ely till	Medical	29a. Certifier 12 Certifying Phy (Check only one)	sicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	red at the time, d	ate and place, and due	to the cause(s)
To the within 2 To the complet	Ž		Negens Mr	2	29c. Licen:	864		9d. Date signed (Mont	4 2005
State	e	30. Name and address of person who concern the second of t	mpleted cause of death (I PERS U.N. p. 1 32 Registrar's Sig	Mgd, Mggnature	dical CINT	er 22 Gr	LEZNE ST.	BALTO, Md	,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary **Physician** Cox Year 08/22/2005 1:00pm^ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/22/1921 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 1 F Days 84 218 09 4652 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Maryland N/A Baltimore Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 1311 Cambria Street 21225 USA or Items 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes → Mo Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be tiled within 72 hours after nent of Health and Mental Hygiene. ent: If item 27 is marked other than "netural", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XNo Specify: Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th 0 Clerk State of MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Jacobs Julia Pavlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Cox / Daughter 1315 3rd Road, Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Depertment of H Importent: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Cen. August 25, 2005 Baltimore MD ` 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 21. Signature Victor Doda Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certiticate be executed the burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery tor 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Be Completed page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 🗆 Yes 2□ No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 \(\text{Homicide} \) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical 29a. Certifie completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Media Hygiene 2 7 9 7 8

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHANCELLOR TARON 20 P M 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 11210 Cedar Lane Kingsville
If Under 1 Year If Under 24 Hrs. Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 1 F Yrs. Director 212-42-8155 08/16/1944 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or itams 23a or 28a-f show 1 ☐ Yes 2X No Funeral Director Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 11210 Cedar Lane 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 5-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Rep. FurnitureBusiness marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be Maurice O. Leister Dorothy L. Harting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Tom Barber (husband) 11210 Cedar Lane Kingsville, Maryland 21087 othar Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ⁴ □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 08/23/2005 Baltimore, Maryland 21. Signature of Fun Septice Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 190 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ovanan Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No of Vital the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide in 24 hours. the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the 6 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) suman D57703 23/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21237 FRANKLIN SO DR 9301 STE 2200 SUMAN 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 6 2005 Registrar

DHMH 17 Rev 1/2001

State Registrar

with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

or Attending Physicien:

			1 - For State Registrar	State of Maryla	nd / Depa	artment of H	ealth and Death	,	2 e0e(Reg. No.	5 2	7980
	367	Ų.	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Mancilla J	Col	eman			AUGUST			7:15a ^M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea	th	4c. C	ounty of Death	
Re Co			1653 VINCENT CT.			BALTIM				N/A	
	Funeral	3	5. Social Security Number 6. Sex	M 2XIF	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da)	i, Year)	Co.	hplace (State or Foreign untry)
Ti-	Director		217-66-8409 Usual Residence of Decedent		49 ''''			8-4-19	956	MAR	YLAND
	yland Now		10a. State 10b. County	10c. (City, Town or Lo	cation					10d. Inside City Limits
	Marfeit	ţo	MD. N/A		BALTIM	ORE					MXYes 2 □ No
	3s or 28	Il Director	10e. Street and Number 1653 VINCENT CT.			10f. Zip Code 2121	7		-	en of What Co USA	untry?
.0	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "neturel", or items 23c or 28e-f ehow marked other than "neturel", or items 25c or 28e-f ehow marked other than Ne Iteal Examination at the retilised at	Funeral	11. Marital Status 1X Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 □Yes 211 No		Was Decedent of His f Yes, specify Cubar	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		1. Race - Amer Black, White	e, etc.
21215-0036	hours a turel', c	ed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Ient's Usual Occupa	Specify:	}		Specify: B]	LACK
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D	be file	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden S	umame)	
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Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	1 18	19a. Informant's Name/Relationship (Tyg ELDRA COLEMAN (FA'			ig Address (Street a					
Baltimore,	s 1 an f Heal Item 2		20a. Method of Disposition	20b	Place of Dispo			Date		ation - City or	
Ê	permit. Pages Depirtment of I Important: If its any injury or o		1 ☐ Burial 2 ☐ Comation / 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify)		-	MEMORIAL	· 1	29-2005	BALT	IMORE.	MARYLAND
att	mit. porta porta y inju		21. Signature of Funeral Service License			RName and Address					
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k	Physician :		23a. Part1. Enter the disease, or complic shock, brheart failure. List only on Immediate duse (Final disease or of indition	cations that caused the de le cause on each line.		er the mode of dying	, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	-						1 Week
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	nted Insit	mlne	Cause (Disease or injury	D40 10 (0) 43 4 00//36	squerice cry.						
	execu in and ial-tra	Examin	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):						
8/60,	cate be executed physician and the burial-transit	dlcal		l							
9		Med	IF FEMALE:		777						
ROX	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3 🗆	Ectopic pregnancy			23	d. Date of deli-	very Day Year
0	at the de by the a tached f	ysic	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5	Other (specify)			İ		,
ב	res that t igned by be detar	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use	ocontribute to	the cause of death?
rds	w requires been sign should be							1 □ Y	es 2 🗌	No 3 Pro	obably 4 Unknown
Hecords,	The law requires that the death certifi tie has been signed by the attending rage 2 should be detached for use as	Completed						24a. Was a		24b. Were aut	topsy findings available ompletion of cause of
		Con						perfor		death?	2 □ No
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Ö	Phys this al dii	5	1 198 2 100	ospital: 1 Inpatient 2		t 3 DOA Othe	r: 4 Nursing I	dome 5 Resid			iify)
lon	al or Attending P s after death. Il Director: After t d in by the funera	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 ☐ Y	at ? es 2 □ No	28d. Describe h	ow injury	occurrea	
DIVISION	al or Att after de 1 Direct d in by t	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Tow	treet and in, State)	Number or Ru	ral Route Number.
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death	occurred at the time restigation, in my op	e, date and place inion, death occ	e, and due to the durred at the time, o	ause(s) ai late and p	nd manner as lace, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	2		29c. License	number	2	29d. Date	signed (Month	, Day, Year)
	Λ		1. Question	Wayle un		02	3089		Augu	ist 25	, 2005
	7		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type,	Print)		01			
			L. Gresto Doylo mo,	Greenslowin	Caucer	Chr., 22	S. Cream	e st., 1	saltiv	nore, 1	40 21201
i like	Sta Registr		L- Greeks Drigle mo, 31. Date filed (Month, Day, Year) ALIG 2 6 2005	32. Hegistrar's Sign	The state of the s						

State of Maryland / Department of Health and Mental Hypiene 5 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sister Therese Mary Dennie, O.S.F. 22, 2005 9:00 A August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 2851 Kentucky Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 11, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 75 June 1930 Delaware Vrs 222-16-0970 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Impurtant: If item 27 is marked other than "natural", or items 23a or 28a-f ehow anyinjury or other traumatic event. The Modical Examiliation and once. 10a State 10b. County 1 X Yes 2 □ No Maryland Baltimore Director N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21213 2851 Kentucky Avenue 14. Race - American Indian, 8lack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 λq 3 Widowed 4 Divorced 16b. Kind of 8usiness/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Administrative Assistant School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Catherine Casey Parnell Dennie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sr. Michelle O'Brien, O.S.F 6112 Wather Ave. Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 8/25/2005 Baltimore, Maryland Most Holy Redeemer 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home, Inc. 5 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCVD Physician /Medical Due to (or as a consequence of): Examiner 22 years Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a o n Examiner Vears diabetes Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 12 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has t page 2 s certificate 1 ☐ Yes 2 9 NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Assidence 6 □Other (Specify) 1 ☐ Yes 2 ☐ No After this c 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: / 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hin 24 hours aft tha Funaral D mptetely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To tha I the 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier 8-23-05 170/22 amence 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osler Drive 502 Towson, Md. 21204 Snyder MD 7505 Laurence 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Gloswa 2005 AUG 2 6 Registrar

CPM 05-05665 Ella Mae Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Tor State Registrar	State of Maryland		artment of He tificate of D			95 27	982
	Physici	an	1. Decedent's Name (First, Middle, Last)	ae Dan				2. Date of Deat Month	Day Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give s		00	4b. City, Town, or I	ocation of Death	August	21, 2005 4c. County of De	
-	Examir	er	2025 West Lexingto				timore		NA	
	Funeral Director		212-10-7117	M 2XF 7. Age (In, yrs. Ia	st.birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	inthplace (State or Foreign Sountry)
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Man	ctor	ma	MA		12al	tem	ore		1 No 2 No
	th with th	rai Director	10e. Street and Number 2025 W	· Lexington	St	10f. Zip Code	-1223	10	Og. Citizen of What C	A
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Iteme 23e or 28e-1 ehow matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	l l	Was Deceden1 of His f Yes, specify Cuban I□ Yes 2 100	panic Origin? (Sp , Mexican, Puerto Specify:	Rican, etc.)	14. Race - An Black, Wh Specify:	3 lack
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<u>ylar</u>	ould be Mental Marked o	To E	EZIEIK	Hurst			Rose	Ann	Hur	ST
Maryland	2 2 2 3		19a. Informant's Name/Relationship (Type Ardeil Hurst -	Sister	19b. Mailin	g Address (Street ar		ig, Calif	City or Town, State,	220-1730
Baltimore,	m O		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Compet (Specify)	emoval from State	ce of Dispo	sition (Name of natory or other place)			20c. Location - City of	
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٩.	s thet the ned by a detac	y Ph	Part II. Other significant conditions con	tributing to death but not result	ling in the ur	nderlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
suds	w requires their speed is been signed is should be det							1 □ Ye	s 2 No 3 1	Probably 4 Unknown
Division of Vital Records,	The la	Completed						24a. Was ar autops perform 1 Tes 2	ned? death?	autopsy findings available completion of cause of
Vita	ding Physician: The Ih. After this certificate he funeral director, page	Be	25. Was case referred to medicat examiner?	ospital:		Other	26. Place of Deat			
0	Phys ar this arai dir	7; To	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury 2	8b. Time of	t 3 DOA	4 Nursing no	me 5 Reside 28d. Describe ho	nce 6 MOther (Sp w injury occurred	ecity) SCENE
ion	anding sath. or: Afte	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		es 2 🗆 No			
	tal or Att s efter de ai Direct ed in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al hon building, etc. (Specify)	ne, farm, sir	eet, factory, office		28f. Location (Sti City or Town	reet and Number or I , State)	Ru <i>ral R</i> oute Number,
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certifica completely filled in by the funeral director, p.	Medical	(0)	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time vestigation, in my opi	e, date and place, nion, death occur			
1	To t To t	Σ	29b. Signature and title of certifier	111		29c. License			d. Date signed (Mo	
	h		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type.		.C.M.E.	A	ugust 22,	2005
_	2		J. Laron Locke M	.D. 111 F	enn S	treet, Ba	ltimore,	Maryland	d 21201	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 6 200	32. Registrar's Signatu	re do	all				
	to the second		400 8 0 200	13 January Ju	-					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 5 27983 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Aug. 24, 2005 11:05 Anthony E. DeMizio /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day.)
Feb. 21, Gilchrist Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Day, Year) **Funeral** 1 XM 2 F Director Yrs. 155-38-5847 55 New Jersev Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits the Middical Examiners wat be notified at 1 Yes 2 No Director Md. Baltimore Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4 Wineleaf Court 21030 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 GL le marked other then Elementary/Secondary (0-12) College (1-4or 5+) School Solutions 4 Sr. Project Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental DeMizio Peter L. Elfriede M. Glasbrenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Mrs. Carol DeMizio/Wife 4 Wineleaf Court Hunt Valley, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
ony injury or otl
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 8/27/05 Timonium, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pancreat **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 ☐ Yes 2 A No certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Rother (Specify) NOSPUL 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 10 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours after To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and interior as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 AUGUST 24 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles ST Tonson, no 21204 Comis MO 31. Date filed (Month, Day, Year) AUG 2 6 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierle 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALISTOWN
I Index 1 Year _ If Under 24 Hrs. GENESIS NURSING BAMMORE HOME 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year

Months Days Birthplace (State or Foreign Country) **Funeral** Hours Min. 1**⊠**M 2□F 217.76.5799 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be notified at 1 ₹Yes 2 No Director MD NIA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a BELMONT AVENUE 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or Itame 11. Marital Status within 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, It a Madia 2008. Elementary/Secondary (0-12) College (1-4or 5+) NA DISABLED 11 TH GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT WYATT, JR. ALDREECE ELLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 BELMONT AVE, WIFE BALTO. MO <u>GWENDOLYN ELLIS</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08.24.05 ' 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FORFST OWINGS MILLS MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHU C. GREENE FUNERAL SERVICE 5151 BALTO NATE PIKE, BALTO MO 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IMMUNE Physician ACQUIRED SYNDROMA DEFICIENCY 3-5428 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last STP Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Records, P.O. by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown PERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 28 No 1 🗌 Yes Division of Vital To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jucaly 2005 DOO 60878 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 09 M D. LI BERTY ROAM RANDALSTOWN 31. Date filed (Month, Pay, Year) AUG 2 6 2005 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 205 PMR CRA6 846 REPHINSTRUM Death Reg. No. 27985 For State State Registrar AMEND ITEM #26 PER G846 846 SEPTE COST OF BEACH PROPERTY OF STATE O 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 16, 2005 **Physician** Janet Leigh Eckhardt 11:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 21, 1951 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F Yrs. Illinois 54 Director 220-60-1220 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1⊠Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1103 Highwood Road 20851 or itams 23a United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 253 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event. Ite Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Marvin Blackburn Rita Ann Smith 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter E. Eckhardt/Husband 1103 Highwood Road, Rockville, Maryland 20851 20b. Place of Disposition (Name of commetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State August 22, 2005 1 \$\textstyle Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician sudden cardine disease or condition resulting in death) m. nutes /Medical Due to (or as a consequence of) **Examiner** athers denote Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be execufed burial-transi Due to (or a la onsequence of): attending physician and for use as the burial-trar Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the al Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ My roidism 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2 No 1 Yes 1 ☐ Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 6 Other (Specify) 2/ No 1 Tes 2☐ER/Outpatient 3☐ DOA 2 this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred a Hospital or Attanding Pl 24 hours affer death. a Funaral Director: Atter t Certification; 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral C 🗍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 059929 a au ry de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland Aaron Snyder, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 6 2005 State

Registrar

	<u></u>		1 - For State of Maryland /	Depa			Mental Hy	,		27986
	Physic	ian	Decedent's Name (First, Middle, Last) William James Eaton				2. Date of Dea	_	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number) Potomac Manor Care		4b. City, Town, o	or Location of Deat		4c. Cou	2005 nty of Death	11:15p
	Funeral		5. Social Security Number 354-22-0931 6. Sex 1⊠ M 2□ F 7. Age (In yrs. last bite of the properties of the propertie		If Under 1 Year Months Days		(Month, Da	h y, Year)		lace (State or Foreign http) nois
	Director		Usual Residence of Decedent	Yrs.			12-09-	1930	Illi	ńóis
	ne Maryla 8e-1 shov	ctor	10a. State 10b. County 10c. City, Tow	m or Lo		shington	D.C.		1	0d. Inside City Limits 1XXYes 2 □ No
	h with ti	al Dire	130 E. St. SE		10f. Zip Code	20003		10g. Citizen d Unit	of What Coun ed Sta	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel", or items 23e or 28e-f show with injury or other treumetic event, the Mcdical Exercipar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Nas Decedent of Nas Decedent of Nas Pecify Cub	Hispanic Origin? (Sean, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	14. R	ace - Americ lack, White, e	an Indian,
Baltimore, Maryland 21215-0036	vithin 72 ho ne. hen "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	OO NOT use retire	during most of word)	rking		Business/Inc	·
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ylan	ould be Mental narked c	To Be	William Eaton			Rose		Ellent	olast	
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ore	ges 1 and of the Ifficent		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	f Dispos	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	wn, State
ij	artmer ortent: injury		' 4 □ Donation 5 □ Other (Specify) Chesa 21. Signature of Funeral Service Licensee		ke Crema		26/05		sville	e, MD
ä	permi Depa Impo eny ir		Style D John M00382	9:	33 GIST A	ess of Facility ral and (Ave., Sil	ver Spri	ng, MI	ices 209	910
. 6	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do a shock, or heart failure. List only one cause on each line.	not ente	er the mode of dyin	ng, such as cardiad	or respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a	of):						
Ø.	100	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		nal disea	ase				
_	cate be executed bhysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c	of):						
8760,	ate be e hysiciar the buria	lical E	d							
.O. Box 6	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				ate of deliver	y Day Year
ds, P.	signed b	by	Part II. Other significant conditions contributing to death but not resulting in	the und	derlying cause give	en in Part I.		pacco use cor		cause of death?
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5	Physicien: r this certifica ral director, p	o B	examiner? 1 Yes 2XXIvo Hospital: 1 Inpatient 2 ER/Out	tpatient	3 DOA Othe	26. Place of Dear	th (Check only on		h /C	
Division of Vital Records,	ding Afte fune	ation: T	27. Manner of Death 28a. Date of Injury 28b. T	ime of njury	Work	/ at <br Yes 2 □ No	28d. Describe ho	w injury occu	rred	
DIVIS	el or Attending F s after death. ol Director: After I d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, stree	et, factory, office		28f. Location (Sti City or Town	reet and Num , State)	ber or Rural I	Route Number,
	To the Hospitel or Attent within 24 hours after deal To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	, death o	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and m ite and place,	anner as stat and due to ti	red. he cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c, License		29	d. Date signe		
	ix (30. Name and address of person who completed cause of death (Item 23a) (Туре, Р	rint)	0054566				, 2005
	JO+1 Sta		Sunitha Bhogavilli M.D., 1220A E	ast	Joppa Rd	1. #230;	Towson,	MD 21	286	
	Registra	-	AUG 2 6 2005 AUG 2 6 2005 AUG 2 6 2005	200	W					

			State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death	Mental Hygio	en 2005	27987
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
ı	Physicia /Medic		Julia O. Eanes		24 2005	1:00 P ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death	
в			Catonsville Commons Catonsville		Baltim	ore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		227-66-1113 62 Yrs.	03/14/19		
	pu 🖈		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	aryla shor	ሯ	Too. State			1 ☐ Yes 2√☐ No
	he M	Director	Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code	10	Citizen of Min of Co.	
	with t				g. Citizen of What Cou	intry?
	s 234	erai	7218 Oak Haven Circle Apt. 103 21244 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.		U.S.A.	ican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1	Rican, etc.)	Black, White	, etc.
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lar	uld by Aenta rkad tic e	To E	Johnnie B. Owens Polly Bo	ooth		
Maryland	short short		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus			
	and 2 auth ar tre		Robert T. Eanes Jr. / Son 7218 Oak Haven Circle	Apt. 103	, Windsor 1	Mill, Md.
altimore,	of He of He litan		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	Oc. Location - City or T	own, State
Ĕ	Pag nent ant: I		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Promise Land Baptist Church Cemetery 08/2	8/2005 A	melia, Vir	vinia
alt	permit. Departr Importu any inj		21. Singulare of Funeral Service Membre 22. Name and Address of Facility The	Derrick	C. Jones F	/H, P.A.
Ω	89 = 89		4611 Park Heights A	ve., Balt	imore, Mar	yland 21215
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition Metatabic Breast Co	ancer		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			7.7
П	Examiner		Sequentially list conditions b.			
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
٧	acute ind trans	Examiner	that initiated events c.			
ő,	e existan surial	ũ	Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dicai	d. ————————————————————————————————————		-	
9	ertific ding p	0	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	that the death certificed by the attending I	Physician/M	250. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
0	the a	ysic	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 Other (specify) 1 Yes 2 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify) Yes 3 Other (specify)			
ď.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death?
ds,	signe d be	d by	Cochexie	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Whitnown
Records,	The law requires that Ite has been signed b oage 2 should be deta	Completed	Maila	04- 346	0.00	Continue and label
3ec	e law has	mpi	175070	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
a				1 Yes 2	No 1□Yes	2 No
Vital	Physician: this certific ral director,	Be	examiner?	th (Check only one)		
o	Physithis aldii	. To	1 Yes 2 No Prospect 1 Inpatient 2 ER/Outpatient 3 DOA 4 Norsing He 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residen 28d. Describe how	ice 6 Other (Speci	fy)
	After fune	ion	1 Natural 5 Pending (Month, Day Year) Injury Work?	Edd. Bosonbo rion	injury occurred	
<u>s</u>	Attending It death. ctor: Afte	ical	3 Suicide 6 Could not be as a Place of Injury. At home form street feature office	28f. Location (Stre	eet and Number or Run	al Route Number.
Division	lor A after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the cau	use(s) and manner as	stated.
	a Fur	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, dat	e and place, and due t	to the cause(s)
	ompl	Me	29b. Signature and title of certifier After 29c. License number	290	d. Date signed (Month,	
	FSFO		> Bled for. mp D36942	2 A	efust 2	5, 2005
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TORAKHIA 1009 Frederick Rd. Cafershi	le, m	2/228	3
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 6 2005 32. Regentar's Signature			

			1 - State of Maryland / Department of Health and N Certificate of Death		giene 2005	27988
}	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Rudy C En Compenda 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea Month		3. Time of Death
	Funeral Director		R-Adams Confey Shock Traving Texter Baltinger 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 69 7 Yrs. 1 Months Days Hours Min.	8. Date of Birth (Month, Day July 28		rthplace (State or Foreign ountry)
	2	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		,1930 PI	10d. Inside City Limits
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Modical Examinar must be notified at	by Funeral Director	10e. Street and Number 12065 Falls Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces?) 1 Never Married 14. Was Decedent tever in U.S. Armed Forces? 1 Never Married 15. Was Decedent of Hispanic Origin? (Sp. Armed Forces) 16. Yes, specify Cuban, Mexican, Puerto Hyss, Give Year or Dates: 1 Yes 2 XINO Specify:		USA 14. Race - Am Black, Wh Specify: A	erican Indian,
121215-0036	filed within 72 ho Hygiene. other than "natura ent, the Mydical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +4 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Insurance Agent 17. Father's Name (First, Middle, Last)		16b. Kind of Business	lndustry
Maryland	2 should be f and Mental B is marked of sumatic ever	To Be		ncia	Guzman	Zip Code)
Baltimore, M	permit. Pages 1 and 2 Department of Health 3 Important: If Item 27 i any injury or other tra <u>once</u> .		1 \(\text{\text{\text{Burial}}} \ 2 \(\text{\text{Cremation}} \) 3 \(\text{\text{Removal from State}} \) \(\text{\text{\text{\text{\text{\text{Ponation}}}}} \) 5 \(\text{\tex{\tex	Date 7/05	20c. Location - City of Timonium, 1 1050	Town, State Maryland York Road
	Prysician /Medical Examiner		23a. Part 1. Enter the glesase, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List opy one cause on each line. Immediate Cause (Final disease or condition resulting in death) a			Approximate Interval Between Onset and Death
8760,		dical Examiner	Sequentially list conditions, family leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Plus to (or as a consequence of): Traunate in Juny Automotive foot Due to (or as a consequence of):	fall from	ladder	2 how 5
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	ivery Day Year
Records, P	w requires that been signed I should be det	by	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Rec	The taw ate has b page 2 s	e Completed	25. Was case referred to medical 26. Place of Death	-	prior to death?	atopsy findings available completion of cause of
of	tending Phys Jeath. tor: After this the funeral dir	Certification: To B	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Hot 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide	me 5 Reside 28d. Describe ho Fall 28f. Location (Str City or Town	nce 6 Other (Spe w injury occurred Q A eet and Number or Ru State)	tral Route Number,
	Hospital 4 hours Funeral ely filled	edicai Co	29a. Certifier (Check only one) 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a composition of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the co	usa(s) and manner as	stated. to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier 29c. License number Au 41764354		d. Date signed (Monte	
	Sta		30. Name and address of person and completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Bardistrar's Signature			
	Registra		31. Date filed (Month, Day, Year) AUG 2 6 2005 Augustar's Signature			

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5	激	Funeral Director
NAME OF THE PARTY OF PROPERTY OF THE PARTY O	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once.
		Physician /Medical
		Medical

cian lical Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the human transit. Box 68760. Completed by Physician/Medical P.O. Records. Division of Vital Be Certification: s after dec.

Reg. No 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician August 24, 2005 6:25 a M Harvey C. Floyd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Feb. 4, 1932 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 249-46-6098 1 **X**M 2 ☐ F South Carolina 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Abingdon Harford Completed by Funeral Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 300D Tall Pines Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Marned Specify: white 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense contract administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Suggs Crossie H. Floyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 306 Rolling Knoll Drive, Bel Air, Md. 21014 Harvey M. Floyd/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 8/27/2005 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a shock, or heart failure. List only one cause on each line. Syndrome with multiple Immediate Cause (Final disease or condition resulting in death) Sepsis reeks Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eroscleratic Cardio-Vascular disense 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ACTI VALVE REPAIR 24b. Were autopsy findings available prior to completion of cause of death? performed? Anewy Sim vef 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 X No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomucide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)25205 in) eath (Item 23a) (Type, Print) Arles St. Balto Md2,204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6

Registrar

		•	For State Registrar	State of Maryland	d / Department of Health and I Certificate of Death		ene 2005	27990
	Physicia	an	1. Decedent's Name (First, Middle, Las	Jagler,		2. Date of Death	Day Year	3. Time of Death A
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	4b Dity, Town, or Location of Death		4c. County of Deat	h
	Funeral Director		X/1-1-00-120>	M 2 F 7. Age (In yrs. Ia	Ist birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day)	Year 9. Birt	hplace (State or Foreign unity)
	the Maryland 28a-f show	tor	Usual Residence of Decedent 10a. Stalls 10b. County	4 10c Biy.	Town or Location AHI MORE			10d. Inside City Limits Nes 2 □ No
	h with the	al Director	10e. Street and Number	34.	10f. Zip Code 2/12/13	10	g. Citizen of What Co	untry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene tem 72 is marked other than "naturet", or items 23s or 28s-f show other traumatic svent. If a Medical Evantial must be notified at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Deves 2 No If Yes, Give Year or Dates:	5. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	nican Indian, a, etc.
21215-0	filed within 72 ho Hygiene. other then "netur ent, I. e Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	college (1/4or 5+)	16a. Decedent's Usual Occupation (Give kind of work dene during most of		6b-Kind of Sulsiness/	ndustry NOYEA
Maryland 2	should be filed and Mentai Hygin s marked other umatic svent.	To Be C	17. Pather's Name (First, Middle, Last)	StER	HANE	B (First, Middle, M	ING	
	1 and 2 sho Health and I som 27 Is mu		f t's Nam- (£1) ionship	awaret-lose	19b. Mailing Address (Street and Number or Richard Street and Number of Ri	ural Route Mumber, Date 2	pfty or Town, State, 2 1110/06 10c, Location - Gity/or	1XC1.21210
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		ty Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	AA UII	metery, crematory or other plage) 1	3-3-15 (1961)	OWINGS I	MIB NO.
8	88 28		23a. Part1. Enter the disease, or comp	olications that caused the death	Do not enter the mode of dying, such as cardial	AA AVE c or respiratory arre	51 121-114 st.	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)		OF CUDGS			Onset and Death
8.2	Examiner	ner	Sequentially list conditions,	b. Due to (or as a consequ	ence of):			
8760,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):			
9	tificate og physi as the	Aedical	were war	d				
O. Box	the death certificate the attending phys ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9☐ Unknown	death 3 Ectopic pregnancy		23d. Date of del Month	ivery Day Year
rds, P.	n requires that the de been signed by the should be detached		Part II. Other significant conditions of HIV DISEASE	-	ifting in the underlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
Division of Vital Records,	has has	Completed by				24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings available completion of cause of 2 No
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one	Property and a second s	
of	Phys this ral di	. To	1 Yes 2 No 27. Many r of Death	1 Inpatient 2 E	28b. Time of 28c. Injury at	dome 5 Resider 28d. Describe hor	nce 6 Other (Spe w injury occurred	cify)
ion	auth. or: After he funer	atlor	1 Natural 5 Pending investigation		Injury Work? M 1 ☐ Yes 2 ☐ No			
Divis	To the Hospitet or Attending within 24 hours after death. To the Funeret Director: Attencompletely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, street, factory, office)	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
	e Hosp 24 hou s Funei etely fill	edical			wledge, death occurred at the time, date and place ion and/or investigation, in my opinion, death occi			
	To the within To the compl	Me	29b. Signature and title of certifier Mulfaux	and no	29c. License number D 166 19		August 23	
	107		30. Name and a dre of person who	completed cause of death (Item	40 FRANKUN SAMAR	EDR.	BACTIMOR	E MD 21236
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture fresh			
DH	MH 17 Rev 1/2		AUG 2 6 2	UUS SERVES	as bear			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiena 0 0 5 27991 For State Registra Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:15 A M ALBERT FOSTER AUGUST 23,2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Baltimore Towson 8. Date of Birth (Month, Day, Year) ADril 14,1931 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1₽ M 2□ F Months Days Hours 215-28-5738 Yrs. 74 Director Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Modical Examiner must be multipal at 1 ☐ Yes 2 No Baltimore Marvland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 East Joppa Road U.S.A. 21286 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Maintenance School Board i. Pages 1 and 2 should be filed writment of Health and Mental Hygie rtant: If item 27 is marked other talury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Foster Julia Born 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte M Shreves (sister) 8001 Pine Barren Court, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Cedan Hill Cemetery 108-27-05 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland and Address of Pasadena, Maryland and Address, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only give cause on each line. 22. Name and Address of Facility 21. Signature of Fugeral Service License 21122 Approximate Interval Between Onset and Death mmediate Cause (Final Pnysician . CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): nding physiclan Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 🗆 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy this certificate has al director, page 2 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the f within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 23 05 Du D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TUWSON MARYLAND 21204

DHMH 17 Rev 1/2001

State

Registra

AUG 2 6 2005

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

MANUS.

State of Maryland / Department of Health and Mental Hygiens 27992 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year FULLER WANDA August 07:13M /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Hopkins Johns Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7/2/56 Birthplace (State or Foreign Country) Funeral 1 □ M 2FXF 212-70-7678 Director 49 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene.
ant: If item 27 is marked other then *neturel; or items 23e or 28e-f show try or other treamster. The Medical Exerting results the neithing all properties and the neithing at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 849 Abbott Court 21202 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 440
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Nurse Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Fuller ဂ Teretha Bacote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Jackson 914 Wilmot Ct. Balto. MD. 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8/24/05 Dundalk, MD 21. Signature of Funeral Service Licenses Wesley Chavis Jr. Funeral Home 2007 Eastern Ave. Balto. MD. 21231 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Hypoxemia

Due to (or as a consequence of): days disease or condition resulting in death) /Medical Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by Physician/Medical Examiner Due to (or as a consequence of). the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed RETroville that initiated events resulting in death) Last Syntrome Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 To the the 2 29c. License number 29d. Date signed (Month, Day, Year) Ani Balmanoukiem, Medical Doctor August 19, 2005 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore Meryland Ani Balmanoullian 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 6 2005

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 27993 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** August 24, 9:35 A M Mary K. Folan /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Manor Care Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Hours 1 ☐ M 2 🖾 F Yrs. November 4,1914 Wash., 90 Director 577-03-6335 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28e-f show treumstic event, the Medical Exact or must be notified at 1 Yes 2 No Director Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 U.S.A. 4858 Battery_Lane #404 Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Clerk/Typist Publishing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H lent; If item 27 is marked ott Be Emma Felber Edward F. Kammerer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11301 Rockville Pike, North Bethesda, MD 20895 J. Patrick May - Durable P.O.A. item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State 8/27/2005 Brentwood, MD ^ 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cem. 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee illiani U 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pelvic Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and al-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician ar Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 🍇 🗓 No Ö the 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Atrial Fibrilation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan Coronary Artery Disease autopsy performed? Jas 1□ Yes 2¬No 3EXNo Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA **4** Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🙀 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Certification: or Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel or within 24 hours aft To the Funerel Di (S) Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 10810 Darnstown Rd., Gaithersburg, MD 20878 Raman Tuli, M.D. 32. Registrar's Signature 31. Date filed (Manth, Day, Year) AUG 2 6 2005 Gerences Registrar

Rlease Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 27994 For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year ROBERT GRIFFIN 08.23.2005 12:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **Ø** M 2 □ F 244.38.3691 76 Yrs. Director 07-22-1929 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at Director NIA 1 ■Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5218 FREDCREST ROAD or items 23a 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specity: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 'natural', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other treametin. Elementary/Secondary (0-12) College (1-4or 5+) 71H GRADE WELDER BETH . STEEL NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILL GRIFFIN MAGGIE MONROE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORA GRIFFIN (WIFE 5218 FREDCREST ROAD, BALTO. MO 21229 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 27^{Pate} 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK 08-22-05 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE ang 5151 BAYO, NATE PIKE, BAYTO, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Hero curaroma Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed -tran and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) o. detached 9 Unknown 9 Unknown been signed by should be detac م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Hiknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed 2□ No of Vital 1 Yes 2 No 1 TYes Be 25. Was case eterred to medical examine? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 2 No ÷ 2 1 es 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifig

30. Name and address of person

31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

23a) (Type, Print) enra

W

strar's Signature

repleted cause

6 2005

29d. Date signed (Month, Day, Year)

			. For	State of Maryland	/ Depa	rtment of h	lealth an	nd Mental H	ygiene	,	
			1 - State Registrar		Cert	rificate of	Death	2. Date of E	Reg. N2	05	27995 3, Time of Death
ı	Physici		1. Decedent's Name (First, Middle, Last) Mary Electa	Guido				Month	Day	Year 2005	6:30 AM
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of [ty of Death	1 //
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	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last	t birthday)_ Yrs.	Months Days		Min. 8. Date of E (Month, I Mar. 4	Day, Year)	9. Birthp Coun Flor	place (State or Foreign htry) Ida
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036	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1	1	☐Yes 2☐ X o	Specify:		Spec	ity: Whi	_te
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	f Heal f Heal item 2 other		Susie Lee Wolfe - 20a. Method of Disposition	20b. Plac	e of Dispos	ition (Name of atory or other pla		ve, Joppa Date	20c. Location		
E C	Page nent o ant: If ary or		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	temoval from State	-	em. Gard	lens 8,				ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show amy injury or other treumatic event. If a Madical Examiner must be indiffied at ODGs.		21. Signature of Funeral Service License	mae 1		Name and Addre		McComas Road, Abi			
	Dr Tra		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cation that call ed the leath. In cause of each line.	Do not ente	r the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
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ord	w require been sig should b							1[Yes 2 No	3 🗌 Prob	pably 4 □Unknown
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visio	f or Attending after death. Diractor: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location	(Street and Nur own, State)	nber or Rura	al Route Number,
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	withi To t	Σ	29b. Signature and title of certifier	MD		29c. Licens	se number		29d. Date sign	ied (Month,	Day, Year)
,	1		30. Name and address of person who co	ompleted cause of death /Item 2'	3a) (Tune 🗆	(Print)	74) 4		Hugus.	r 25	2005
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	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 6 20	and manner stated. MD propleted cause of death (Item 23) 32. Pegistrar's Signature 05	2 60	edei			/		,

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	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last Terry Lee G: 4a. Fecility Name (If not institution, give SAINT AGNES HO	4.					Day	Year .005 of Death	2;05 PM				
e de la constante de la consta	- Funeral Director		5. Social Security Number 6. Se		n yrs. last birthday) 56 Yrs.	If Under 1 Months		f Under 24 Hours N	Ain	Date of Birth (Month, Day pt. 9	Year)	Cou	olace (State or Foreign ntry) 1 Dakota		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic avant, the Medical Evantrar must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Baltimon 10e. Street and Number		Oc. City, Town or Lo		Code				Og. Citizen of V		0d. Inside City Limits 1 ☐ Yes 2 🗷 No		
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed Taylor and the state death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	CANCER	ience of):										
		icai Examiner	d										DAYS DAYS		
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			3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
			(Check only one) 29b. Signature and title of certifier	ner: On the best of mer: On the basis of ex and manner stated	n my opini License ni	ion, death o umber	occurred a	t the time, da	ate and place, a	Pate signed (Month, Day, Year)					
	6	,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIYANKA NELLORI, 900 CATON AVENUE, BALTIMORE, MARY LAND -212 31. Date filed (Month, Day, Year) AUG 2 6 2005 AUG 2 7 2005												
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GIBBS, TERRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August **Physician** 2005 2:00 p M Genschel 1 Anne /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore White Hall 2803 Anderson Rd. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Au Gont 283, 19923 9. Birthplace (State or Foreign New Yersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F 142-16-4589 81 Director Usual Residence of Decedent s filed within 72 hours after death with the Maryland I Hygiene. other than "naturel", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Clark 1 Yes 2X No Union Funerai Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 07066 210 Valley Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) i. Pages 1 and 2 should be fill thent of Health and Mental Hitent: if Item 27 is marked off ijury or other traumatic even Pafrodt Dora Ruberti Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 Anderson Rd. White Hall, Md. 21161 Debra Ostrowski/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)
Fairview Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any injury or once. 8-26-05 Westfield, NJ * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funefal Service Licensee ²Rwck^{an}fowson^{Farw}neral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cheese Art 1917) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chrone Obstrictive Line DX 4 Donknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed 2 Z No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: 1 ZNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: After thi death. I Director: d in by the within 24 hours a To the Funerel I

Baltimore, Maryland 21215-0036

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Mark lama M

29c. License number

29d. Date signed (Month, Day, Year)
08 -22 - 05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Lamos, MD 9 Schilling Rd. Hunt Valley, Md. 21030

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

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31. Date filed (Month, Day, Year) AUG 2 6 2005

4 Homicide

29a. Certifier



State of Maryland / Department of Health and Mental Hygiene 2005 27998 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2105р м Theresa J. Hohman August 23,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9235 Harford View Drive Baltimore Parkville 8. Date of Birth (Month, Day, Year) 9. Birthplace (State County)
NOV. 20, 1923 MAryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1□ M **%**□ 217-14-3088 81 Director Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County 28a-f show ral', or itams 23a or 28a-f shov Exeminer must be notified at 1 Yes 2X No Baltimore Director Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9235 Harford View Drive 21234 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Head of Personal Ft. Howard 10th Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, II once. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph K. Zanto Katherine Bryjawski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Hohman 326 S. Taylor Ave. Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ₩ Burial 2 Cremation 3 Removal from State St.Stanislaus 8/29/05 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do/, and ter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Arterioschootic Cardiovascular Disease Physician 20 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown jo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical exagniner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1) 18667 August 24,2005 who completed cause of dealn (Item 23a) (Type, Print) Trimble Hill CT. Lutherville, Mary land 21093

DHMH 17 Rev 1/2001

State

Registrar

Philip Militello, MD 31. Date Ved (Month, Day, Year)

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32. Registrar's Signature

Physician /Medical **Examiner**

Funeral Director

P.M

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Physician /Medical Examiner

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after death. Director: Af the filled in by ö within 24 hours

8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 ☐ M 2 🖫 F 103 564-40-2959 1901 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Timonium Md. Baltimore 1 ☐ Yes 2 ☐ **X**No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2300 Dulaney Valley Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White ģ 3 NWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Hair Salon 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Perrin Laura Trahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Holly Branch Ct. Glen Arm, Md. 21057 Mrs. Jacqueline Schnee/ GDTR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Most Holy Redeemer 8-27-05 Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Licenses 23a. Part1. Enter the discusse, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each of the death. Approximate Interval Between Onset and Death 1/2vioselsvetic C384/10/13/24 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Oth cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Vds es/or 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: Wursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD21093 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

AUG 2 6 2005

			For State Registrar	State o	f Maryla	nd / Depa	artmer <i>rtificat</i>	nt of H	lealth a Death	and N	fental Hy	giene Reg. No.		05	280	000
			Decedent's Name (First, Middle, Last) 2. Date of Death									ath			3. Time of E	Death
	Physici /Medio		Joan Kauper Henze								Month August	22 .		Year 5	1422	2 M
	Examir		4a. Facility Name (If not institution	n, give street and nui	mber)		4b. City,	Town, or	r Location of	of Death	11108000	4c. County of Death				
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕅 F	7. Age (In yrs	s. last birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bir	th Vear	- 0		ace (State or try)	Foreign
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumatic event, the Medical Examination at ange.	5												''	0d. Inside City 1 □ Yes :	
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Baltimore,	t. Pa rtmer rtant:		4 Donation 5 Other (S		1	Pai	∶k		; ,	2005		Roc	kvil	le, 1	Maryla:	nd
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<u>Ф</u>	Attending Physician: The law requires that the death certif redeath. - death. - ector: After this certificete hes been signed by the attending ector. After this certificete hes been signed by the attending by the funeral director, page 2 should be detached for use as	h Š	9 Unknown	3 DOUKHOWH												
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٦	ding Ph h. After thi funeral	ö	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury	2	28c. Injury Work?			28d. Describe how injury occurred					
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Division of Vital Records,	l or Attene after deatl Director: s in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)					et, factory, office 2			28f. Location (Street and Number or Rural Route Nu City or Town, State)				Route Numbe	er,
٢			29a. Certifier 1% Certifyin	a Physicis - T- (1	hant of mult		_									
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	00		30. Name and address operson	who completed ca	of death (Ite	m 23a) (Type. i	Print)		/		I A	sugus	s L 23	, 20	UD	
	30		George F. Seng	100				rive	, Whe	ator	ı, Maryl	Land	209	06-4	709	
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